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Otitis Externa

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A COMBINATION of heat and humidity and rain during the hot months in this area contributes to the activity of fungi and bacteria in the air, on the land, and in the lakes. The skin, clothes, shoes and bed clothes of people are clothed with spores and bacterial growths that propagate tremendously. These members of plant life get into the most annoying warm, moist and protected places such as between the toes, in the eyes, and outer ear canals and in the saddle region. Man's curious fingers apparently carry the infestation from place to place. During this time the sebaceous glands and cerumen glands of the outer auditory canal are more active, their secretions quite fluid and less viscous and their open mouths more open than in cooler months. These factors permit ready and easy access to the subcutaneous tissue through the sebaceous and cerumen glands, thus permitting the spread of infection to underlying soft and yielding surrounding tissues. In contrast to the above, the inner part of the canal is lined with thin, flat, smooth, sensitive, dry skin, devoid of hair, containing a minimum of glands. It is stretched tightly over the osseous auditory canal and continued over the tympanic membrane.

In a routine examination of the external auditory canal it is not unusual, although not frequent,

to observe white or white-black granular or flat growths of mold or fungus on the epidermis. Innocent and peaceful, they remain without complaints from the patient and confined to the inner bony canal. I have never seen it so on the skin of the cartilaginous portion; in fact, the results of its having gained speedy access into the sebaceous and cerumen glands is what we hear about and see.

The Unit Surgeons must treat the bulk of these conditions, which are caught early, and from them I have learned that various medications such as cod-liver oil; ichthyol and glycerine; phenol and glycerine; tincture mercuric; sodium sulfadiazene, and sodium salicylate with buffered alcohol; sulfa powder mixtures and others have been sufficiently efficacious to effect many cures. The cases we get in the clinic evidently are the ones that get out of control, out of which number, many require hospitalization. Bacteriological studies usually reveal a mixture of aspergilli, streptococci, staphylococci, and short bacilli. Staphylococcus and streptococcus dominate the routine culture reports.

Etiological factors are interesting when the men state that they had "no ear trouble" until:

1. They went in swimming, following which an earache began within one to three days
2. They took a shower the night before
3. They awoke one morning digging their ears
4. They felt an itchiness in the ears
5. They felt an earache for no reason at all.

Diagnosis

The disease process may be confined to the: (a) osseous portion of the canal, (b) cartilaginous portion of the canal, (c) both portions.

From the Eye, Ear, Nose and Throat Clinic, AAF Regional Station Hospital, Orlando Army Air Base, Orlando, Florida.

Because the skin in the osseous portion is thin, devoid of secretory elements and hair follicles except along the roof, it follows and is borne out by clinical observation that the infection is slow to gain a foothold and may lie dormant until a favorable medium in the form of water or perspiration is supplied. This moisture aids growth and devitalizes the thin skin to allow an entrance into the subepithelial tissue. One observes that the pale, parched, clean, and tidy canal has turned to redness and swelling, associated with earache. The details of drum and canal are lost in a rosy dimness and white or white and black moldy concretions lie on the surface of the epidermis or on an accumulation of dark brown wax. Of course, you can't see the streptococci or the staphylococci. The earache is not affected by movement of the lobe and may cause insomnia. Hearing is not affected sufficiently to interfere with the usefulness of the soldier. Audiograms reveal no more than a ten to twenty decibel loss of hearing.

Serous and hemorrhagic blebs, especially the latter, are frequently found on the inferior and lateral aspects, causing a marked encroachment on the lumen and adding to the duration of the disease. You will observe the absence of pulsating discharge, serous or purulent. If a pulsating discharge is present, a co-existing otitis media is concluded which in our clinic has been noticed twice and must be kept in mind. After the painful phase has passed the course may be prolonged in a few cases by continuous thick, fatty, purulent-like secretion emanating from the epidermis on the ceiling of the canal and adjacent drum head. Continuous daily treatment up to twenty-one days will usually effect a return to normal in these reluctant cases.

The cartilaginous part of the canal seems to be the one that we see most frequently involved in the Eye, Ear, Nose and Throat Clinic. Early in the disease process the epidermis is red and thickened, the lumen narrower, canal tender on palpation, ear lobe painful on movement and insomnia. There may or may not be a greasy, thick, macerated material in the lumen. Sebaceous and cerumen secretion becomes (1) diminished, (2) paralyzed early, (3) becomes re-established after the acute phase has begun to subside. This serous-sebaceous, milky discharge supervenes because:

1. Of a lack of vigorous early treatment.
2. Of the presence of an acute exacerbation of an underlying eczematous condition.

3. Of the use of medications that encourage glandular secretion, consequent epidermal thickening, and stimulation of infected foci lying in and around these glands.

The infection progresses to a point where the canal is practically obliterated and a small cotton-tipped, steel applicator cannot penetrate farther than the bony hump on the floor of the lumen. As this stage regresses you will, within the next few days, find that your small applicator will pass through this bottleneck and just drop or give into the space between the hump and the drum. Should one or few glands become involved while the rest of the canal is not affected, an external otitic furunculosis is present. Treatment for this affair follows the general lines of treatment, and does not include incision. The only time incision or a healthy excision of skin is made into or over a furuncle is when the acute stage has passed and a soft, fluctuating tumor is palpated in the wall. Ample drainage is thus obtained and general treatment follows.

Treatment

- A. General: (1) Outpatient; (2) Ward patient.
- B. Local: (1) Inner canal; (2) Outer canal.

The treatment followed in the outpatient clinic and on our ward has been set up with the thought in mind that we are dealing with a condition that may be prolonged unless dealt with in an energetic manner, so that the soldier may return to duty and classes as speedily as possible.

A. (1) The general treatment of the clinic outpatient is:

1. Two glasses of water every hour during the day.
2. One capsule consisting of sulfadiazine gr. V and soda bicarbonate gr. X (sulfa and soda caps) to be taken after meals and two at bedtime. This is an adult dose.
3. Hot boric acid compresses are applied to the affected ear for twenty minutes every two hours.
4. One AFCC (Air Force cold capsule) (codein sulfate gr. 1/2, atropine sulfate gr. 1/400 and aspirin gr. X) is taken thrice daily, after breakfast, after supper, and at bed time.

A. (2) The general treatment of the patient in the ward is subject to two regimes. The first one is known as "First Day Standing Orders." This consists of:

1. Bed rest.
2. Four hundred c.c. of water, taken by mouth every hour.
3. Sulfanilamide gr. V and soda bicarbonate gr. XV, taken at the hours of 8-10-12-2-4-6-8. Sulfadiazene gr. VII 1/2 and soda bicarbonate gr. XV to be taken at 9-11-1-3-5-7-9.

4. Sulfadiazene and soda bicarbonate alone may be used hourly, instead of the above regime, from 0800 to 2100, with an additional dose of 1 gm. at 2130.
5. If penicillin is available, an intramuscular dose of 25,000 units is given every three hours until the swelling and pain and inflammation have completely subsided. This very effective medication may be used exclusively or in conjunction with the sulfa regimes.
6. Hot boric acid compresses are applied to the affected ear for twenty minutes every hour.
7. AFCC are given before meals and at bedtime to control pain.
8. Morphine sulfate gr. 1/4 is ordered as required for uncontrolled pain.

The patient is automatically started on this procedure as soon as he is bedded in the ward. Another automatic sulfonamide order is termed "Second Day Standing Orders." This plan is similar to the First Day Standing Orders with an exception. The sulfadiazene and soda medication is deleted from the routine in paragraph 3.

Second Day Standing Orders are continued daily thereafter until discontinued or changed to First Day Standing Orders in order to speed up a reluctant or tardy infection. Sulfanilamide is favored for the streptococcus infections and sulfadiazene for staphylococcus, pneumococcus, and meningococcus infections. Soda and sulfa pills are given by the hour, on the hour, plus a maximum water intake, for an average sulfa level in the blood of 10 to 12 mgms. per cent. The nurse brings the medication to the patient and stands there until one glass of water has been consumed with the pills. After making her medication rounds of the ward she repeats, with another glass of water to each patient. This procedure seems adequate to keep the pH of the urine around 7. Few people like water, especially the tasty brand we have here during the hot days, and if you do not stand there beside them, those cola and pop-hopped addicts will not drink it.

9. Diet. An allergic factor may aggravate or prolong the resolution of externa otitis. Since many of the annoying allergic factors are found in liquids and desserts that are consumed, the patient is put on "water only" for liquids and beverages. Desserts are also eliminated to give advantage to soups, salads, raw and cooked vegetables, meat, dark bread, butter, and cheese.

Local Treatment

Local treatment varies with the presence of infection in the outer (cartilaginous portion) or the inner (osseous portion) auditory canal.

Osseous Canal.—The treatment at this early stage consists of:

1. Daily gentle syringing of the ear canal with

two to three steel syringefuls of body-warm water or 50 per cent peroxide.

2. Remove all moisture and discharge from the canal with a cotton-tipped steel applicator, a small tipped aspirator and an air pressure tip.

3. Application of medicine. This may be done with an applicator (cotton-tipped steel) whereby the walls are (1) painted or, (2) the medication poured in, using an eye dropper, followed by a firmly fitting cotton plug inserted to the depth of the bony hump on the floor. Application is done daily. Medicines used and applied by the Unit Surgeons are:

- (a) Cod-liver oil.
- (b) Tr. mercuric.
- (c) Sodium salicylate in alcohol.
- (d) Sodium salicylate, sodium sulfadiazene and 70 per cent alcohol buffed with sodium hydroxide.
- (e) Alkaline aluminum subacetate or Burrow's solution.
- (f) Five per cent acid aluminum acetate.
- (g) Gentian violet.
- (h) Ten per cent ichthyol and glycerine.
- (i) Five per cent phenol and glycerine.
- (j) Sulfonamide powder mixtures.
- (k) Equal parts of 5 per cent aluminum chloride in 70 per cent ethyl alcohol and 5 per cent sodium salicylate in 70 per cent ethyl alcohol.
- (l) Five per cent aqueous mercurochrome.
- (m) Equal parts of a 5 per cent aqueous mercurochrome and a saturated solution of boric acid.
- (n) Five per cent sulfadiazene water-soluble face cream.
- (o) Five per cent sulfanilamide ointment.

A third method of application is using two cotton-formed wicks. The inner cotton wick impregnated with medication is so placed in the canal that it is snug to the walls without being packed. The outer wick is packed firmly into the outer canal so that: (1) It will hold the inner wick in place as it tends to fall out or the enlisted man is prone to dig or pick it out. (2) It absorbs an excess of medication in the inner wick. (3) It prevents an excess of medication from running down the patient's neck. (4) It prevents the inner wick from drying out. (5) It prevents the possibility of fungus and bacterial additional contamination while the patient is under treatment.

The reason the inner packing has to be snug without packing or pressure is because the penetrating solution will destroy the epidermis of the osseous portion of the canal and leave painful small round potholes on its floor or sides or perforate the tympanic membrane.

A tardy postacute infection on the drum may be hurried to termination with light applications of 10 to 50 per cent silver nitrate.

Hemorrhagic blisters are frequently broken and pain abated over night by instituting the antiseptic

tic and anaesthetic action of 1 per cent to 5 per cent phenol and glycerine solution or they may be gently incised. Should the canal become so diminished as to obliterate the drum landmarks, immediate hospitalization should be considered as the patient requires general hospital and local treatment. It usually takes about three weeks to cure these cases with an occasional associated or coincidental perforation and an otitis media, acute.

Cartilaginous Canal.—Here we contact the most frequent locality of infection as well as the most frequent locality of canal deformity and swelling in and around the ear. The same medications may be used. Packing with cotton wicks in the outer canal may be more vigorously and enthusiastically applied. This depends on how much the patient will comfortably endure. The hospital ward patient attends the Eye, Ear, Nose and Throat Clinic daily. Time of treatment is between 0645 and 0800. On account of the accumulation of ward patients ranging from twenty-five to fifty in number at times, it was found expedient to have these men treated before the clinic patients started to "jam the waiting room." By 0830 all ward patients were in bed again so the head nurse could:

1. Change or activate the orders on the Doctor's Order Book, thus avoiding a delay in treatment.
2. Be able to send the respective patients to mess as well as classify those who are or were attending the convalescent program.

Medicines, past and present, recommended, donated, bought, and read about have been and are being used. (The collection has been listed above.) The medicines used should have the following properties:

1. The medicine should be in a state of continuous application to the walls of the diseased canal.
2. It follows that it should be non-irritating and painless but penetrating.
3. It should be non-corrosive in order that it may be packed lightly or tightly in the canal so that swelling or canal deformity may be arrested and diminished and thus localize the infection. The medicine-loaded packing will prevent further spread of infection into normal tissue, as well as stop sebaceous gland activity with subsequent thinning of the epidermis, and so reduce the infectious activity. Another point to remember is the possible activity or re-activation of

an allergic secretion. In such a case an alcohol or irritating medication would not be beneficial.

Our experience in this hospital leads us to conclude that 5 per cent aqueous mercurochrome is the most efficient medicine. The advantage that mercurochrome has lies in:

1. Its property of staining and penetrating diseased areas.
2. Its ability to form dry, red, coagulated crusts that overlie healed areas.
3. The ease with which these crusts are syringed off the normal pink or pale areas revealing the red stained diseased areas.

Gentian violet also stains diseased areas but it is not amenable to syringing from normal areas. It has a depressing color in contrast to the lively crimson color of mercurochrome.

The local and general treatment is continued and it is found that:

1. The pain was controlled or had subsided after one to two days.
2. Canal deformity reduced on or about the third to fifth day.
3. Patient went to duty on or about the seventh day.
4. Cases complicated with circumaural edema, cellulitis, or involvement of tympanic membrane usually cleared up in from fourteen to twenty-one days.

After the acute phase has passed and the lumen of the auditory canal has returned to its normal size, a light coating of hot sulfanilamide powder, blown into the canal, may be substituted for the pack to absorb further moistness. A thin crusted plaster is formed which can be easily removed by gentle syringing.

Any eczematous dermatitis that remained following the infection phase usually yielded separately or in combination to 10 per cent to 50 per cent silver nitrate or 5 per cent boric acid ointment, or hot sulfanilamide powder.

The additional use of 70 per cent ethyl alcohol as a swabbing or cleansing agent in the receding stage is beneficial:

1. To remove the mercurochrome crusts.
2. To determine the presence of unhealed areas in the ear canal through the burning sensation complained of by the patient.

A survey was made of the number of eye, ear, nose and throat patients admitted to the AAF

Regional Station Hospital and to the Eye, Ear, Nose and Throat Clinic at Orlando, Florida. Three thousand personnel was the average case load served by this specialty each month for the year of 1943. The following observations were made on the subject of external otitis, for the period of March to December, 1943 (inclusive):

Hospital Cases

Total: 130 Cases

- I. Days in hospital:
- (a) Shortest 1 day
 - (b) Longest 21 days
 - (c) Over ten days..... 13 cases
 - (d) Average 6 days
 - (e) Average excluding the
above 13 cases..... 5 days
- II. Recurrences 2 cases
- III. Uncomplicated cases with
old perforations..... 2 cases
- IV. Associated with otitis media,
acute, suppurative..... 2 cases

Clinic Cases

Month	Treatments	New Patients	Average Number of Treatments
March	82	8	10
April	92	12	8
May	171	20	8
June	264	47	5
July	423	57	7
August	622	130	6
September	468	77	11
October	304	28	11
November	146	14	10
December	119	12	10
Total	2684	407	6.7

July, August and September were found to yield the heaviest load and it is interesting to note the average number of treatments per case was around six. This was true for hospital cases as well as clinic cases. A contributing factor to the higher number of treatments per case for the fall and winter months is the stubborn eczematous, allergic or other dermatitis that has its basis as a rule in some underlying constitutional defect.

Conclusion

1. A technique is offered for the treatment of otitis, externa, acute and chronic.
2. The parenteral use of sulfonamide and/or penicillin in conjunction with the packing of 5 per cent aqueous mercurochrome alone or in equal parts with saturated solution of boric acid has made the treatment of this disease a joy to the doctor and a pleasure to the patient.

JUNE, 1946

Benadryl in Hay Fever, Asthma, and Vasomotor Rhinitis

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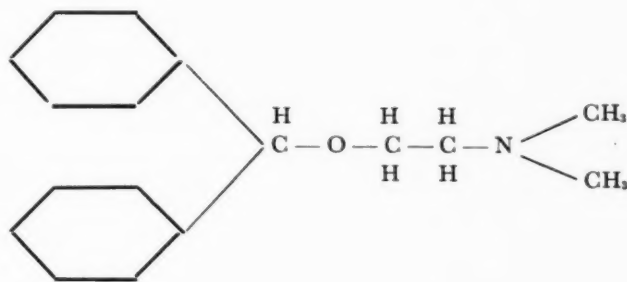
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THIS is a preliminary report on use of Benadryl† in the management of certain manifestations of allergy in eighty-seven cases including hay fever, asthma, and vasomotor rhinitis.

Benadryl is a white crystalline powder, soluble in water and alcohol. It is stable under ordinary physical conditions. The chemical name is Beta-dimethylaminoethyl benzhydryl ether hydrochloride and its structural formula is:



Benadryl belongs to a new and distinct pharmacologic group of compounds with specific antihistamine action. The term *antihistamine* designates chemical compounds which prevent at least some of the pharmacologic actions of histamine. Animal experimentation^{1,2,3,5} reveals that Benadryl antagonizes the effects of histamine on smooth muscle in the bronchioles and intestines of guinea pigs,

*Deceased.

†Benadryl supplied by the Department of Clinical Investigation, Parke, Davis & Co., Detroit 32, Michigan.

BENADRYL IN HAY FEVER—BARNETT ET AL.

TABLE I. CLINICAL RESULTS WITH BENADRYL IN FORTY-SIX CASES OF HAY FEVER

Name	Sex	Age (yrs.)	Duration of Illness (yrs.)	Skin Tests	Length of Treatment	Dosage	Side Reactions	Result
H.K.	M	11	3	spring grasses and dandelion	2½ mo.	100 mgm. daily	none	complete relief
L.C.	M	54	15	spring and fall pollens	1 mo.	Parenteral 2 cc 150 mgm. daily	slight drowsiness and nausea	complete relief
L.K.	M	15	6	fall pollens, wheat, fish, eggs	3 mo. 2 days	150 mgm. daily	slight drowsiness	very much improved—essentially free from symptoms
B.K.	M	4	2	early grasses, fall pollens, deep sea food	2 mo. 5 days	Elixir 150 mgm. t.i.d.	none	sleeps well—breathes easier much improved
F.K.	F	35	16	spring grasses, early fresh fruit, cheese	3 mo. 3 days	150 mgm. daily	drowsiness four days	marked improvement 10-25-45 complete relief
B.L.	M	15	4	fall pollens	3 mo. 5 days	100 mgm. daily	drowsiness marked	marked improvement
C.M.	F	30	10	none	5 weeks	100 mgm. daily	none	improved
L.M.	M	32	30	fall pollens	25 days	Parenteral 1 cc 100 mgm. q 3 hrs.	slight drowsiness	not improved
J.P.	F	50	25	fall pollens, house dust, some foods	4 weeks	50 to 100 mgm. daily	none	much improved
J.P.	F	30	10	none	2 mo. 22 days	50 to 150 mgm. daily	slight drowsiness	complete relief from symptoms
M.R.	M	38	2 weeks	none	5 weeks	50 mgm.	no report	incomplete
H.R.	M	11	3 weeks	early grasses, fall pollens	2 mo. 1 day	Elixir 25 mgm. t.i.d.	none	marked improvement
A.S.	M	28	10	pollens and yeasts	2 mo. 21 days	50 mgm. daily 1 cc. Parenteral q 72 hrs.	extreme drowsiness	complete relief
S.S.	F	20	since childhood	early grasses, fall pollens	3 mo. 9 days	150 mgm. daily	none	marked improvement with complete relief during mid-season
R.T.	M	14	10	fall pollens	1 mo. 12 days	100 mgm. daily	none	improved
G.K.	M	31	10	not done	6 weeks	150 mgm. to 200 mgm. daily	slight drowsiness	improved by taking 200 mgm. daily—nose still blocked though
L.G.	M	16	3	fall pollens	5 weeks	150 mgm. daily	none	marked improvement
P.N.	M	53	5	fall pollens	3 days	150 mgm. daily	severe drowsiness vomiting	some relief but discontinued medication
S.Z.	F	40	24	fall pollens	5 weeks	100 mgm. daily	none	complete relief
H.B.	M	28	15	fall pollens	2 mo.	150 mgm. daily	slight drowsiness for 8 hours	marked improvement with several days of complete freedom from symptoms, then complete relief
L.S.	F	32	6	house dust fall pollens	3 mo.	100 mgm. daily	slight drowsiness	complete relief
R.H.	F	30	5	fall pollens	5 weeks	200 mgm. daily	none	marked improvement at first, then complete relief
N.T.	M	17	5	not done	6 weeks	150 mgm. daily	slight drowsiness 24 hrs.	complete relief
H.B.	M	69	31	fall pollens	3 mo.	150 to 200 mgm. daily	slight drowsiness	complete relief
C.B.	M	30	10 days		14 days	150 mgm. daily		incomplete
L.B.	M	30	15	fall pollens	5 weeks	150 mgm. daily	none	improved
B.B.	M	49	40	fall early grasses and pollens	3 mo. 18 days	150 to 200 mgm. daily	drowsiness and slight nausea	has had some bad days but on a whole has shown much improvement
E.C.	M	56	17	fall pollens	9 days	100 mgm. daily	none	improved
M.F.	M	40	5	none	15 days	50 mgm. daily		incomplete

BENADRYL IN HAY FEVER—BARNETT ET AL.

TABLE I—CONTINUED

Name	Sex	Age (yrs.)	Duration of Illness (yrs.)	Skin Tests	Length of Treatment	Dosage	Side Reactions	Result
H.F.	M	48	2	fall pollens	4 weeks	150 mgm. daily	slight drowsiness	complete relief
H.G.	M	15	5	fall pollens epidermals	4 weeks	Elixir 150 mgm. qid	none	marked improvement
W.H.	M	51	8	none	1 mo. 11 days	50 mgm. daily	none	slight improvement
H.H.	M	43	17	fall pollens	1 week	100 mgm. daily	marked drowsiness to stupor	discontinued medication due to drowsiness
T.Z.	M	9	5	wool, fall pollens				incomplete
S.K.	F	35	20	foods, fall pollens	5 weeks	150 mgm. daily	slight drowsiness first 72 hours	complete relief of symptoms
E.S.	F	45	15	none	7 weeks	100 mgm. daily	slight drowsiness 48 hrs.	complete relief
R.Z.	M	7	5	none	5 weeks	100 mgm. daily	none	improved
H.L.	F	20	10	foods spring fall pollens	5 weeks	100 mgm. daily	none	marked improvement
G.P.	M	30	10	fall pollens	4 weeks	150 mgm. daily	none	immediate and prolonged improvement
G.W.	F	19	10	epidermals fall pollens	2 mo.	100 mgm. daily	none	relieved
N.P.	F	23	2	fall pollens	3 weeks	150 mgm. daily	none	complete relief
A.H.	F	59	20	fall pollens	1 mo. 4 days	150 mgm. daily	none	improved
B.C.	M	58	25	fall pollens house dust foods none	1 week	100 to 300 mgm. daily	drowsiness fifteen days	no improvement
R.Z.	M	7	4	fall pollens house dust foods none	3 weeks	150 mgm. daily	none	improved
A.G.	M	36	10	fall pollens	1 mo.	150 mgm. daily	none	improved
K.G.	F	40	8	fall pollens	6 weeks	150 mgm. daily	none	improved

and appears more potent, in this respect, than any compound heretofore described.

Benadryl alleviates histamine shock and anaphylactic shock in guinea pigs. This probably results for the most part, from reduction in bronchial constriction. It is probable, also, that the vaso-depressor effects of histamine are partly abolished; in anesthetized dogs, Benadryl partly suppresses the vaso-depressor action of small, intravenous doses of histamine. Experimentally, it has been demonstrated that a practical maximal inhibition of about 94 per cent is obtained with 4.0 mg. per cent per Kg. of Benadryl. In addition, it has been demonstrated that a constant per cent of any dose of histamine appears to be antagonized by a given dose of Benadryl—as measured by blood pressure response in dogs.

Table I summarizes clinical data in a series of forty-six private patients with hay fever. Five may be eliminated as incomplete because patient cooperation was lacking. Of the forty-one remaining, only one may be recorded as manifesting only

indefinite clinical results. Forty showed complete relief or very marked symptomatic improvement. All patients, within two to three days after initial therapy with Benadryl, exhibited significant clinical improvement including decreased itching of the eyes, nose and throat and a decided decrease in nasal and postnasal discharge, improved nasal ventilation and a general feeling of well being.

Results in the thirteen cases of asthma summarized in Table II are inconclusive. Six patients revealed definite improvement, two felt worse, five reported no improvement.

Analysis of results in the twenty-eight cases of vasomotor rhinitis summarized in Table III reveals seven cases symptom-free, seventeen cases improved, three unimproved, and one case in which the complaint was apparently aggravated. This is the most common group seen by the rhinologist and is sometimes called allergic rhinitis, atopic rhinitis, and paroxysmal rhinorrhea. Both perennial and seasonal cases are represented. One observer⁴ claims the majority of chronic nasal symptoms seen

BENADRYL IN HAY FEVER—BARNETT ET AL.

TABLE II. CLINICAL RESULTS WITH BENADRYL IN THIRTEEN CASES OF ASTHMA

Name	Sex	Age (yrs.)	Duration of Illness (yrs.)	Skin Tests	Length of Treatment	Dosage	Side Reaction	Results
B.C.	M	58	25	fall pollens house dust	7 weeks	200 mgm. daily	none	improved
T.M.	M		6	pollens	4 weeks	50 to 300 mgm. daily	none	asthma slight improvement
M.F.	F	74	10	dust	4 weeks	50 to 150 mgm. daily	sleepy and nausea at times	slight improvement
R.L.	F	24	14	dust fall pollens	4 weeks	50 mgm. daily	very drowsy at first	no improvement
B.B.	M	49	40	pollens	4 mo.	50 to 150 mgm. daily	dryness in throat	improved
E.W.	F	21	10	none	6 mos.	150 mgm. daily	none	improved
J.S.	M	5	1	none	1 mo.	30 mgm. daily	none	improved
A.H.	F	69	20	spring and fall pollen	4 mo.	150 mgm. daily	none	improved
I.G.	M	25	8	food feathers	4 mo.	100 mgm. daily	drowsy at first	improved
J.E.	M	53	16	dust, eggs, potatoes	4 mo.	150 mgm. daily	nausea	no results
F.S.	F	44	22	none	2 mo.	50 to 150 mgm. daily	none	no results
P.N.	M	53	5	fall pollens	1 mo.	150 mgm. daily	numbness	no results
S.B.	F	37	18	foods	2 mo.	150 mgm. daily	none	slight improvement

in office practice are of allergic origin, house dust being responsible for 90 per cent of cases seen.

Dosage

All patients studied received the same basic dosage management with Benadryl. Not knowing its clinical effects on our patients, we initiated therapy in each instance with a dose of 50 mg. Benadryl (capsule) once daily after the evening meal for two to three days. Provided no untoward reaction developed and the patient's symptoms were not relieved, dosage was increased to 50 mg. twice daily; then after one week dosage was increased to 50 mg. t.i.d. p.c. When a dose of 50 mg. Benadryl was associated with untoward symptoms, the dose was reduced to 25 mg. or to 10 mg.

Each case must be studied for maximal response to dosage that does not produce side actions. We have observed therapeutic benefits from dosages varying from 30 to 150 mgm. daily in divided doses. Some patients respond best to evening medication but most patients may take Benadryl in divided doses throughout the day.

Forms of Medication

Benadryl has been used by us in the following dosage forms:

1. In powder form; 50 mg. capsules.
2. In Elixir form; 10 mg. per dram.
3. In sterile solution for parenteral use; 10 mg. per c.c.

There are advantages and disadvantages in each dosage form of Benadryl which will be discussed in a subsequent paper. For the present we have used one or all at the same time, with the same clinical results. The Elixir is preferable in treating children; parenteral medication is advisable when gastro-intestinal symptoms manifest themselves.

Side Actions

In this series of eighty-seven cases, the untoward symptom most frequently complained of was mild drowsiness lasting from one to one and one-half hours. Occasionally severe drowsiness lasting eight to twenty-four hours made patients apprehensive. In a few cases nausea was experienced but this soon wore off and was then not bothersome. Several patients complained of mild bladder disturbances, such as frequency and discomfort.

All patients who have had side effects while receiving Benadryl have been studied as to blood pressure levels. Most of these patients presented a hypotension with drowsiness. Therefore, a stimulant in the form of Amphetamine Sulphate was used. Dosage of this medication depended on systolic pressure. Those patients in whom the reading was below 110 systolic were given 5 mg. of Amphetamine in the morning repeated at noon when necessary. In those whose systolic blood pressure was above 110, 2.5 mg. of Amphetamine was used once or twice daily. This therapeutic

BENADRYL IN HAY FEVER—BARNETT ET AL.

TABLE III. CLINICAL RESULTS WITH BENADRYL IN TWENTY-EIGHT CASES OF VASOMOTOR RHINITIS

Name	Sex	Age (yrs.)	Duration of Illness (yrs.)	Skin Tests	Length of Treatment	Dosage	Side Reactions	Results
J.B.	F	16	1	none	2 mo.	50 mgm. daily	none	symptom free
M.B.	M	59	10	none	3 mo.	50 to 150 mgm. daily	drowsiness	improved
V.B.	M	37	16	pollens foods positive	2½ mo.	50 mgm. daily	weakness and drowsiness	symptom free
H.L.	M	34	17	none	2½ mo.	100 mgm. daily	none	symptom free
M.M.	M	38	3	none	3 mo.	150 mgm. daily	drowsy	symptom free
N.P.	M	17	2	foods pollens positive	3 mo.	150 mgm. daily	drowsy at first	improved
A.P.	F	47	12	foods pollens positive	2 mo.	100 mgm. daily	dizziness at first	improved
J.W.	F	20	6 mo.	foods positive	3 mo.	50 mgm. daily	drowsiness at first	no improvement
R.J.A.	M	46	10	none	2 mo.	150 mgm. daily	none	improved
F.B.	M	63	10	none	4 mo.	200 mgm. daily	none	improved
R.C.	F	33	9	house dust positive	2 mo.	50 to 150 daily	none	improved
J.C.	M	69	2	none	2½ mo.	150 mgm. daily	none	improved
L.F.	M	61	40	none	5 mo.	100 mgm. daily	none	improved
L.F.	F	33	1	foods positive	2 mo.	150 mgm. daily	none	improved
I.G.	M	25	8	none	3 mo.	150 mgm. daily	none	symptom free
J.G.	M	49	27	dust positive	3 mo.	150 mgm. daily	nausea at first	improved
F.K.	F	35	16	foods pollens positive	3 mo.	150 mgm. daily	none	improved
J.K.	M	2	2	negative foods	3 mo.	50 mgm. daily	none	symptom free
A.K.	M	48	3	none	2 mo.	50 to 150 mgm. daily	none	improved
C.L.	M	58	7	foods pollens positive	4 mo.	50 to 150 mgm. daily	nausea at times	improved
S.L.	F	17	2	food epidermals positive	3 mo.	150 mgm. daily	sleepy at first	improved
A.M.	F	50	6 mo.	foods epidermals positive	1 mo.	50 to 150 mgm. daily	drowsy	no results
A.M.	M	30	2	foods positive	6 weeks	150 mgm. daily	none	no improvement
M.P.	F	23	2	fall pollens positive	2 mo.	150 mgm. daily	none	symptom free
N.P.	M	17	2	foods pollens positive	2 mo.	50 to 150 mgm. daily	none	improved
L.R.	M	12	1	foods pollens positive	2 mo.	50 to 150 mgm. daily	nausea and drowsy at first	improved
M.S.	M	45	7 mo.	house dust positive	2 mo.	50 to 150 mgm. daily	drowsy at first	improved
E.W.	F	21	10	none	4 mo.	150 mgm. daily	none	feels worse

agent apparently acted favorably in overcoming all side effects of Benadryl, including bladder disturbances.

Most allergic patients present more than one

manifestation of allergy; further study is necessary to evaluate all steps in their management with Benadryl. However, this preliminary report reveals that Benadryl has proven of great help in treat-

ment of certain types of allergy. Best results were obtained in hay fever, and vasomotor rhinitis; clinical results in asthma were less favorable. None of our cases developed serious toxic reactions.

In a subsequent report the entire series of cases of the present group, plus additional cases that may be added, will be covered as to the following statistics: Age, Sex, Complaint, Diagnosis, Duration of Treatment, Results, Untoward Reaction and Management of Same.

Conclusion

In conclusion, we present our findings concerning a new treatment for allergy, in the form of medication called Benadryl. We have covered the following subjects:

1. Theory
2. Nature of the Drug
3. Types of Cases Treated
4. Case Reports
5. Statistics of a Group of eighty-seven cases
6. Dosage
7. Results
8. Complications and Their Management

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PANTS

There are certain events in this valley of strife
That provide our starved souls with a thrill
For they serve us as landmarks the rest of our life
In this sphere of monotonous drill.

But of all such events that will raise a man's hope
And that no other thing quite supplants,
For it gives a sick man such a boost up the slope,
Is the day he gets back into pants.

CHARLES G. FARNUM, M.D.
Illinois Journal, April, 1946.

Therapeutic Abuse of Thyroid Substance

By William S. Reveno, M.D.
and
Robert C. Moehtlig, M.D.
Detroit, Michigan

IN THE THIRTY YEARS that have elapsed since the isolation of thyroxin by Kendall, many important studies and much valuable experience have been recorded regarding this agent and the thyroid substance from which it is derived. Clinical application of this knowledge at first followed the investigative effort at a respectful distance, due regard being displayed for the demonstrated potency of the agent in use. With the passage of time, however, an increasing impunity for the dangers involved and an almost total disregard for the basic criteria have replaced the earlier caution. Now it is quite ordinary to prescribe .2 gm. (3 grs.) or more daily for an indefinite period on the sole basis of a complaint of tiredness and a single basal metabolic rate determination; and, as favorable response fails to materialize dosage is increased in some instances up to 6.2 gm. (10 grs.) per day and continued at this level indefinitely as long as the patient registers no complaint. Occasionally the physician may be puzzled by the early development of a generalized myalgia in patients with actual hypothyroidism who have had too much thyroid. This reaction to overdosage, indicative as it is of the small amounts of thyroid substance necessary for the control of a specific disturbance, emphasizes the need for lifting prescription writing for this potent agent from the automatic to the conscious level.

This tendency towards overdosage and its attendant disregard for consequences has other important implications. Not only is it slovenly therapy but it indoctrinates the thyro and the borderline practitioner who practices by ear with the idea that use of thyroid substance (and other positive acting drugs) is attended by all gain and no risk. This unhealthy trend was pointed up by the following experience and stimulated the present discussion:

A white man, aged forty-seven, was started on .4 gm. (6 gr.) thyroid daily because of sexual impotence and the finding of a BMR of minus 30

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per cent. After six weeks his original complaint was completely forgotten, having been replaced by nervousness, insomnia, palpitation, sweating and weight loss. In spite of discontinuing medication, the disturbance continued during the next three months and was only finally terminated after six weeks of thiouracil therapy.

A second patient, a white man, aged thirty-eight, complaining of tiredness and backache and found to have a BMR of minus 40 per cent, was given .2 gm. (3 gr.) thyroid daily for the next six months when he developed palpitation, nervousness and weight loss which continued in spite of discontinuing medication. After another four months auricular fibrillation developed. The induced hyperthyroidism was in this instance also finally controlled with thiouracil.

Though these instances are extreme, they are the results of an all too common practice which must produce disturbances in function and inter-relationship, if not in structure, of many body tissues and organs. These are often unrecognized because they remain at a subclinical level.

It is apparent that the therapeutic virtues of thyroid substance have been emphasized so strongly as to overshadow its harmful potentialities and create carelessness in its administration. Perhaps a review of the better known actions of this many-sided agent may serve to restore a semblance of balance with a fuller appreciation of its potency.

Effect on the Pituitary

First it is necessary to bear in mind that the thyroid is a target organ even though its power and influence over other organs and tissues is impressive. It is far from autonomous, depending for its smooth functioning on the good will and co-operation of a number of satellite organs, and looking to the anterior pituitary gland as its guiding star. Disturbance in this latter relationship has a most important bearing on the general body economy and should accordingly be discussed first.

In the reciprocal relationship between the thyroid and the pituitary, the thyroid secretion affects the pituitary as strikingly as the thyrotropic hormone affects the thyroid. A reduction in the amount of thyroxin stimulates an increase in thyrotropic principle which causes hyperplasia of the thyroid acinar epithelium. At the same time the basophils in the pituitary become of maximal size, are increased in number and show vacuolation—the so-called “castration” or “thyroidectomy

cells.” Excess thyroid secretion or feeding on the other hand, causes enlargement of the acidophiles with increased brilliance of the granules and hypertrophy of the golgi apparatus and mitochondria. The basophiles, however, appear to be affected in the same manner as in undersupply of thyroid secretion. In the neural posterior lobe or in the diencephalon-hypophyseal system, there is an increase in posterior lobe secretion (pituotrin). At the same time hyperemia of the entire pituitary gland takes place.

Translated into effects, the hyperemia of the gland and the stimulation of the diencephalon-hypophyseal system may well account for the headache, nervousness, insomnia, sweating, polyuria and polydipsia, and, in extreme instances, the hypertension and glycosuria that may follow excess thyroid feeding. The evidence seems to point to a derangement of the vegetative nervous system of varying degree and permanence due to its vulnerability to thyroxin.

As for the effects of the changes occurring in the anterior portion of the gland, these may be both immediate and remote. Prolonged dioestrous and persistent functional corpora lutea have been noted in rats and may explain the various menstrual derangements, oligomenorrhea, irregularity, and amenorrhea, occurring with long continued thyroid feeding.

The most significant though remote effects are those involving the connective tissues of the body. In the liver, changes resembling early cirrhosis and interlobular hepatitis may develop. In the osseous system osteoporosis with increased calcium excretion can occur. Acceleration of bone growth may take place in the young. The muscular system may suffer through the development of weakness or hypotonia. All of these disturbances may of course exist at a subclinical level remaining unrecognized but producing cumulative damage nevertheless.

Effect on the Liver

Mobilization of liver glycogen is known to follow thyroid administration. In the presence of a small extra amount of thyroid hormone the tendency of the liver to discharge sugar is increased. This is probably brought about through sensitization of the liver to stimuli which promote discharge of glycogen.

Long continued action of this sort can readily result in liver glycogen depletion of varying degree. If small amounts of extra thyroid are taken this depletion is not complete, but with large

amounts the depletion is more complete and the action of insulin is accentuated to the point of production of hypoglycemia. In any event, the constant interference with glycogen storage in the liver and the constant leakage of glucose into the blood stream is far from wholesome to the body economy and can eventuate in serious disturbance of the carbohydrate metabolism.

Effect on the Adrenal

It is generally believed that an excess of thyroid hormone either stimulates the production of extra adrenalin or sensitizes the body tissues thereto. Depletion of liver glycogen mentioned above is a direct result either of increased sensitivity or exposure to greater amounts of adrenalin. Increased sensitivity of cardiac muscle to adrenalin with development of anginoid symptoms deserves serious consideration when long continued administration of thyroid extract is contemplated.¹

An antagonistic relationship exists between the thyroid and adrenal medulla. Hypertrophy of the suprarenals following the administration of thyroid substance has been observed and this may be interpreted as a compensatory attempt to inhibit the activity of the thyroid. This reaction is responsible for the difficulty in eliciting symptoms of hyperthyroidism by feeding thyroid to an animal with an intact thyroid gland.¹ If continued over an extended period it could constitute an important factor in the development of myxedema in patients in whom long-continued thyroid feeding was suddenly stopped. Another factor in this paradoxical development might well be the tendency of the thyroid gland to become inactive during the administration of thyroid substance.

Effect on the Pregnant Woman

Irreparable damage to the brain of the fetus, resulting in mongolism, may result from overdosage of thyroid substance to the pregnant mother. As an example, a woman, aged twenty-eight, who had been on .65 gm. (10 gr.) of thyroid daily for a period of ten years became pregnant and continued to take the same dose until full term. Delivery was normal, but the child was a Mongolian idiot. We feel that the excess thyroid caused damage to the central nervous system.

This same experience was repeated in another young woman, a nurse of twenty-six, who took 0.325 gm. (5 gr.) daily during her pregnancy and the child was a Mongolian idiot. Such large doses of thyroid seem uncalled for and the effect of

overdosage on the pituitary and thyroid of the fetus, in the light of experimental and clinical studies, would indicate that the effect is a deleterious one. The natural consequence of the fetal thyroid and pituitary disturbance induced by thyroid substance overdosage could well be the clinical condition Mongolism. We are not of course stating that Mongolism is always caused by the administration of thyroid but feel that this drug may, by overdosage, produce fetal thyroid and pituitary changes with resulting damage to the brain and other tissues. Changes in the pituitary have been repeatedly demonstrated in Mongolism (Benda), and it is interesting to note that feeding of large doses of thyroid have resulted in changes in the pituitary similar to those found in Mongolism. Certain it is that one must be cautious in the administration of thyroid during pregnancy.

Effect on Growing Children

Another field where the abuse of thyroid is widely prevalent is in that of pediatrics. In growing children, comparatively large doses, .065 (1 gr.), over a period of time results in a negative calcium balance. This produces osteoporosis with lordosis, kyphosis and scoliosis. Further, thyroid is often prescribed whenever it is felt that an endocrine condition is present no matter what gland is primarily at fault. Obviously such chance prescribing carries with it a certain amount of danger.

Effect in Obesity

The error in depending on thyroid substance for weight reduction in the obese is now quite generally recognized (or is it?). Wilder² has stated the case so succinctly that his words are worth quoting:

"When an adult man or woman adds to his body weight his BMR remains within what are called normal limits; that is to say, the calories per square meter of surface are unaltered. Actually they may be moderately increased, but the important consideration is that the number of square meters to be reckoned with increases, and as the surface enlarges, the total basal heat production increases materially. At the same time the muscle mass and the size of the organs, with the possible exception of the heart, remain as they were before weight was gained. The increase in surface is attributable exclusively to adipose tissue, and since such tissue is very inert chemically and contributes only meagerly to the increased change of energy, the extra metabolism is nearly all thrown on the unchanged mass of muscle and organ. It formerly was supposed, incorrectly, that the metabolic rate was lower than normal in obesity. The contrary is the case; the metabolic rate of the chemically active tissues of the body, its muscle and organ mass, is in-

creased to a degree which is quite as great as we ever encounter in goiter. Incidentally, this is a very good reason for not using preparations of thyroid in the treatment of obesity."

Summary

The abuse of thyroid substance is quite widespread and is fraught with risk to the patient. It is ordinary experience to find as the sole basis for its administration any one of a wide variety of symptoms or complaints combined with a low BMR, too little thought being given to the fact that the basal metabolic rate is not the sole measure of thyroid activity. Improvement that has followed in some instances has stimulated trial treatment in more and more patients with unwarranted increase in dosage and a growing disregard for consequences.

Among the recognized ill-effects of overdosage are: (1) induced hyperthyroidism; (2) potential derangement in the vegetative nervous system; (3) changes in the connective tissues of the body such as have been noted in the liver; osteoporosis and increased calcium excretion; and muscular hypotonia and weakness; (4) disturbances in menstruation; (5) interference with carbohydrate metabolism by depleting the liver of its glycogen; (6) sensitization of tissues to adrenalin; (7) hypertrophy of the adrenal medulla with compensatory suppression of thyroid activity; (8) inactivity of the thyroid gland, with development of myxedema upon cessation of thyroid feeding; (9) Mongolism; (10) dangerous increase in the metabolism of active body tissue in the obese.

When it is recalled that normally the function of the thyroid gland is to maintain the level of thyroxin in the body at 14 mgm. (or 70 grains thyroid substance), or to elaborate 0.33 mgm. (approximately 1.6 gr. thyroid substance) of thyroxin daily, and that the gland can be largely resected and the remnant still continue to deliver the normal amount of thyroxin, the wastefulness of large doses becomes clearly evident.

In this discussion the intent has been not to deny or discount the value of thyroid substance as a therapeutic agent. Rather has it been the purpose to recall the real and potential ill-effects of overdosage and to discourage the tendency to give thyroid substance when in doubt, stepping up the dosage in the hope that if a little is good a lot is proportionately better.

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Adoption Procedure and Medical Practice Under the New Law

The Role of the Physician

By David Feld, M.D.
Detroit, Michigan



WITH ever-increasing frequency, the physician is confronted with the problem of patients desiring children to adopt. If he is not only an ethical but also a conscientious doctor, the problem is almost too overwhelming in its complexity for him, as a single individual, to solve. The facts

of the situation are multiple, and, therefore, numerous factors have to be clarified. Moreover, because of the great confusion that has previously existed regarding the adoption of children, and because of the many "shady" adoptions that have been perpetrated in the past, the need for more comprehensive legislation to help solve the difficulties became apparent. The result was Michigan's new and, as far as can be foreseen, excellent adoption law.

The prevalence of involuntary sterility is great. It is generally estimated that one in every eight or nine couples is sterile against its will, and that there are in this country two or three million married couples of reproductive age desirous of children but unable to have them. Many such couples present themselves to the physician for help in their problem. The thorough doctor will do careful diagnostic studies on these sterile couples to determine their fertility index. Some of them will be absolutely sterile. In others, given even a low fertility index, attempts are made to achieve a pregnancy. The attempts are usually given thorough and prolonged trial, sometimes without a gratifying result. It is in these, and in the absolutely sterile couples, that the solution of the problem ultimately resolves itself into the adoption of a child.

Most couples come to this end of their long sterility—or fertility—survey with some reluctance. The reluctance varies in degree with each indi-

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vidual couple. However, when the average sterile couple accept the conclusion of their own sterility and the necessity of adoption in order to have any children, they are by this time usually very anxious to get an adoptable child. Much time has been spent in a thorough sterility study; they have already waited some time before they undertook the study, and they are now most impatient. To further complicate the problem, it is estimated that there are ten prospective adopting parents for every one adoptable baby.

Somewhat naturally, many sterile couples look to their physician to find a baby for them to adopt. My natural reaction is to refer them to the proper agencies for information and help concerning this entirely different phase of the sterility problem. The physician rightly believes that he is the one most competent to deal with the medical aspects of a sterility problem. By the same token, he should be the first to acknowledge that the social agencies and the courts are the most competent to deal with the social, psychiatric, and legal intricacies of an adoption. Under the wise provisions of the new law, the physician will be doing his patient a great favor by seeing to it that she is referred to the social agencies for the solution of her adoption problem. Only in this way can the legal, medical, and social traps of an adoption be avoided.

Medico-Legal Aspects of Adoption

The new adoption law sets up a definite legal procedure which protects the inherent rights of the natural mother, the child, and the adopting parents. In addition, it tries to eliminate the possibility of shady adoption procedures which attempt to circumvent the adoption laws.

There have been instances in which pressure has been placed upon a natural mother to give up her child for adoption when such may not have been her primary desire. This has not infrequently occurred when a not too scrupulous or ethical doctor delivers a patient, who, he believes, because of certain economic or social pressures, could be induced to place her child for adoption. Such a physician usually has another patient who is very desirous of adopting a child. Because of a forthcoming, and lucrative, fee from the adopting parents if such a deal could be engineered, it is attempted. All the natural mother might want in this case is some help in making necessary arrangements to keep her baby. This help the social

agencies are glad to render. The natural mother may not realize this fact, and under the above circumstances, no social aid would be forthcoming to help her realize this. Moreover, if such an adoption were attempted, all parties involved might get into difficulties later after the child had been theoretically "adopted." Frequently, such adoptions are not legally foolproof. The natural mother might "change her mind" later on; the doctor can get into trouble because of his involvement and acceptance of the large fee; and the adopting parents may have to give up the child after becoming quite affectionately attached to it. Such cases have been called to my attention, and I am sure, to yours.

The legal machinery of the new law attempts to eliminate such happenings. The natural mother must, through a very definite procedure, signify her desire to place her child for adoption. Her natural rights to the child are terminated permanently.

The elimination of these problems assumes that the machinery of the law is employed. Very frequently the doctor finds himself the middleman in an adoption procedure. He may have a patient very desirous of adopting a child, and he may have a woman very desirous of having her child placed for adoption. The doctor may be most ethical and conscientious in his wish to further the interests of both patients. He may try to consummate such an adoption very legally, without the questionable purpose of merely trying to get a big fee. However, he may rightly expect to be paid for his services. If such a procedure is not done strictly according to the law, his fee, if not approved by the probate judge, is an illegal receipt of money for an adoption. The physician is thereby involved in a legal tangle, of which he had no previous conception.

The doctor, however, may frequently find himself with an adoptable child and very desirable adopting parents, both of the involved parties still being his patients. In such circumstances, he may rightly wish his patient, the adopting parent, to have preference in getting this adoptable child, whose natural mother is also his patient. It would be to his great safety and advantage to accomplish this adoption through the authorized channels. I am sure that the social agencies would be glad to co-operate with him in this request, if all other factors are approved, and see to it that his patient received this particular child.

Medical Aspects of Adoption

The new adoption law, if followed, provides for a great margin of medical safety. The thorough investigation of the child's physical and mental status before placement, and the one year waiting period give the adopting parents a great deal of security in that they will not be saddled with an inferior child. If, during the one year waiting period, the child seems inferior in development, the adopting parents are not bound to keep him.

Previous to this new law, there were innumerable instances wherein adopting parents took a questionable baby, sometimes a supposedly normal infant, without any previous investigation. Not having the one-year waiting period, or being afraid to wait for fear of losing the baby due to some hitch in the legal proceedings, the child was adopted immediately. As time went on, and the baby turned out to be subnormal in either physical or mental development, the adopting parents were bound to the child legally and emotionally. Years of anguish, heartache, expense and responsibility followed. Many of these adoptions were sponsored by doctors, who then not only regretted them, but also were blamed for them. The doctor is no soothsayer, nor should he take it upon himself to play that role. He should be the first to recognize the importance of thorough investigation of the baby, and of a waiting period to verify the infant's normal development. Unfortunately, in his sincere wish to be of service to his sterility patient or an adopting parent, he frequently forgets or neglects this important phase of the adoption. He wishes to help his patient as quickly as possible. The new law, in putting a check rein on his enthusiasm, will also be doing him a great service, and will protect him against later and possibly life-long recrimination.

Social Aspects of Adoption

This phase of an adoption investigation does not belong to the doctor. I do wish, however, to mention it since the doctor so often tries to usurp this domain in his adoption efforts.

When the average physician has some specific adopting parents for whom he is trying to obtain a baby, the only prerequisite the doctor usually considers is his patient's economic ability to care for a child. This is indeed an important factor, but only one of many. I am firmly convinced that the adopting parents' social and psychiatric devel-

opment, and their background in a broad cultural sense, are extremely important, as well as their physical and mental health.

The physician most certainly does not have the time or the means available to check all these factors. Frequently he does not have the interest or the vision to realize the great part these factors play in the ultimate development of the child. Since the physician's adoption investigations would most probably be quite narrow, I feel that he should not be an agency in his own eyes, or consider himself capable of deciding upon an adoption placement. Moreover, I have seen and taken care of sterility patients, who, in my private opinion, would have made poor parents because of poor psychiatric and social development. I am personally pleased, therefore, to have adoption decisions taken out of my hands and placed in the hands of the social agencies. I feel that patients will more willingly accept an agency's decisions as more impersonal and just than my own. A patient can be made to realize the amount of investigation which substantiates the judgment of a social agency. An agency can camouflage more readily the reasons for its rejection of certain applicants, in favor of more desirable adopting parents, than the doctor can possibly do.

As I have already intimated, the lack of a careful social investigation can be disastrous. Race, creed and color of both child and adopting parents should be carefully investigated and matched as closely as possible. I have heard of many cases where the parents, and sometimes the child in later life, have suffered severe mental trauma because of the discovery of a great mistake in race, creed or color.

I am sure that you have gathered from my remarks that I am greatly impressed and pleased by Michigan's new Adoption Law. I think it gives promise of working out splendidly, if only given the co-operation in all ways that it merits. I, for one, am delighted to turn over to the social agencies and to the courts a problem which is rightfully in their own field!

MSMS

Little Joe Genius says—

I see that Mr. Dingell says that the national health bill has been "subject of more wilful misrepresentation and misinformation than any other piece of legislation" in his thirteen years in Congress. I agree with him.

I see Mr. Ickes, the old curmudgeon, is in favor of the new version of the national compulsory health bill, but admits he hasn't read the bill *in toto*, nor can he remember what parts he has read.

Cancer Education in a Rural Area

By Albert E. Heustis, M.D., M.P.H.†
Coldwater, Michigan



COMMUNITY planning for health education in the field of cancer has been uniquely demonstrated in a rural Michigan county. To the best of our knowledge this is the first time that physicians, lay groups, teachers and school children have worked together in a co-ordinated rural pro-

gram of cancer information.

The idea originated with L. E. Davidson, publisher of the *Coldwater Daily Reporter*, who offered to provide the financial backing. He sought the advice of the Cancer Consultant of the Michigan Department of Health and asked the County Health Department to participate.

A planning meeting was arranged and several interested citizens met with representatives of the County Medical Society. The consultant presented his idea of a continuing cancer education program and the Director of the County Health Department was elected general chairman.

The objectives established were to induce those with suspicion of cancer to consult their own physicians early and to provide the doctors with help in establishing the diagnosis of early cancer.

The first step was to tell the story of cancer—what it is, and what can be done about it. This was designed both to provide general information and to remove the fear which has so often stood in the way of an early diagnosis. It was directed at every person in the county through the schools and through others who would read or listen.

The State Consultant prepared a series of brief, factual, understandable articles on "The Story of Cancer," which were prominently featured on the front page of our local paper. In addition, both the Consultant and the entire staff of the County Health Department made themselves available for group discussions. Our health educator was of great help in arranging the schedule. She canvassed the community groups and worked through their

program committees. The Farm Bureau, granges, service clubs, mother's clubs, study groups, parent-teachers' associations, and township organizations were brought into the plan. For the most part the talks given were illustrated with slides or movies and in each case supplemental printed material was available for distribution.

The libraries participated in the project by the display and circulation of cancer information.

In the schools the program started with a series of five two-hour illustrated talks for high school science teachers. These were later expanded to include anyone who was interested. Four of the sessions were given by the Cancer Consultant while the fifth was presented by several members of the Medical Society.

Next, in the school plan, came a number of single talks to high school students at assemblies and in certain classes. These were frequently illustrated, time was allowed for discussion and printed material on cancer was made available to supplement the basic facts presented. Moreover, instructional units were given to high school teachers for use in their classes.

The final step in the school program provided for distribution of literature on cancer to every student in every school. This material was intended for the parents as well as the pupils. Extra copies were made available for distribution to homes not represented by the school children.

The portion of the program designed to help the doctors was developed into a Cancer Teaching Day. Cases suitable for operation and certain diagnostic problems were assembled by the local medical men and three qualified and capable specialists were invited to come out from the state university and spend an entire day in our rural hospital. These included a gynecologist, a general surgeon, and an internist. The morning was given over to an operative clinic of three cases and ward rounds, while a general tumor conference of seven cases was held in the afternoon. In the evening, the visiting doctors presented illustrated talks on "Cancer" at a dinner meeting of the Medical Society to which physicians from the surrounding territory were invited.

The fine public spirit of our local newspaper publisher served both to crystallize public sentiment about our cancer problem and to focus it into an active, protective, participating program. It could not have been done as completely or as effectively without his genuine interest.

†Director, Branch County Health Department, M.D., University of Michigan 1936. Four years Department of Surgery, M.P.H., Johns Hopkins, 1942. Monroe County Health Department until July 1, 1945.

The Strength of Unity

Throughout the centuries man has been besieged with periods of restlessness which try his soul, and they occur most often in the wake of war. He seeks change in order to escape dilemma; sometimes for his own good, while on other occasions he may take a stand shaded with disappointment because too little thought has been given to where the new course will lead.

Perhaps no group of individuals has kept up with the progress of time more thoroughly than the medical profession. It has been careful to weigh its shortcomings, and has been first to make way for promising new methods, yet slow to accept the unknown until there is sufficient evidence of correctness to warrant approval. The average practitioner cannot now see the necessity of overthrowing all the results of the many years of experience and progress, together with all the advantages gained by the public from careful evaluation of medical economic problems for something unknown; for ideas of service that, because of their complexity, will take years to work out, if ever. When future health service plans are perfected for public approval it is certain the medical profession will be in the lead.

Purveyors of the idea of controlled medicine would like nothing better than to see discord within our ranks. They fear solidarity of purpose. Fortunately for the people of this country there is unity within the society of doctors of medicine, and at no time in the history of this nation has it been so important that unity of thought and purpose should prevail.

With the help of organized medicine level headed leaders in the United States Senate are bringing forth proposed legislation to co-ordinate the health functions of the Federal Government in a single agency, together with some other provisions to expand the activities of the Public Health Service. The medical profession can well support this type of legislation for it follows our ideals, and ideas of service which can be offered to protect the public from the sting of catastrophic illness, without the drawbacks a compulsory system is sure to bring. The strength of 170,000 doctors of medicine is being felt. The newly proposed legislation has a good chance of passage, and let it be the answer to proponents of political medicine.



President, Michigan State Medical Society

President's



Page

Editorial

IS THIS STILL AMERICA?

WE ARE REPRINTING ON page 740 an editorial from the *Rocky Mountain Medical Journal* giving specifically the background of the Wagner-Murray-Dingell Bill now being considered by Congress. These facts have been printed in less detail before, but we are busy people and are apt to forget. Also about 40 per cent of our members have been in the war service, the military forces, and not in direct contact with what has been transpiring here at home. Those of us at home have been too busy taking care of our own work, and the patients of our absent confreres to have time to keep abreast of the undercover happenings.

America was settled as a place of refuge, a place of freedom of worship, of freedom from government controls, a place of *liberty*. Our forebears came to this land to escape regimentation and compulsion in many of their life ambitions. They wished opportunities they could not get at "home." They wished for their children freedoms and release from restraint which during the ensuing centuries have made this the most advanced, the healthiest, the most prosperous nation on the globe. Their children and their children's children have attained a standard of living never before attained in this world. This has been accomplished through opportunities of action and advancement restricted only by lack of ability.

But now foreign ideologies are being insinuated into our beloved land. A new theory of life is offered. All must be guaranteed "SECURITY." They must be guaranteed freedom from worry, a guaranteed income during old age, health services at the expense of the government. Our forefathers who made this country of ours scorned such molycoddling. They demanded and made for themselves opportunities to work and provide for their families the advantages they wanted. They cut the timbers, tilled the soil, worked the mines, built the roads and railroads; they hewed out their own salvation, and in doing so built the most advanced nation time has ever seen.

Now we are told this is all wrong. We must have "compulsory" old age pensions. We must have "compulsory" unemployment insurance. We must have "compulsory" personal health insurance.

These things have come to us as the trend of social development. We are told this last addition to the compulsory things we must have is not socialized medicine, but the very vehemence with which the proponents deny the facts shows their appreciation of having trod very close to the edge.

The persistence with which the social-minded groups have grasped this attempt to socialize and to dominate the rendering of medical services *to the people who can pay* raises a question of the real reason. Is it the unadulterated urge to do good that inspires them? If so, why neglect the indigent in the compulsory service group? Is it a desire to build a bureaucracy in the hope of furnishing medical services to those who already can and do get what they want of medical services? The proposed plan would set up great bureaus to fatten on the needs of the sick of the nation. They would not provide a single additional doctor to do the work, but they would place the doctors now in practice under a control which would limit their ambitions, and amount of work. They ostensibly would allow him independence to choose which patients he would serve. He could still do private practice if he could find any patients. By the lack of private patients he would be regimented to do the work of the bureaucrats.

Have these political control artists given us a fair deal? They have restricted debate on this bill to include only nationally organized groups. State medical societies who wish to be heard may write out and submit briefs. They will then be published in the hearings so that anyone who wishes may read. The American Medical Association was given one day. Have these politicians given the humble public, the person who needs a doctor, and wants his own doctor, any chance to be heard? No. They are not nationally organized. Unfortunately the most interested person or group in matters of health service might just as well not exist. He has no voice.

Politics does strange things. It makes jobs out of heartburns. It perpetuates itself by finding new avenues and new dogmas. Has the time arrived when we must face the facts of the inadequacy of the American People to provide for themselves? We feel it has. We feel the great majorities of our

people must awaken to the imminent threat of compulsion being thrust upon them by wire-pulling off-stage minorities.

SCIENTIFIC CONFUSION

GEORGE MEANY, Secretary of the A.F. of L., describes the new wage-price regulations as "Scientific Approach to Confusion." He protests that "the administration has loaded the dice for its favorites while framing the rules against the balance of the nation's workers."

A representative of the A.F. of L. (Crookshank) told the delegates at the recent Conference on Medical Services in Chicago that the union recognizes the ability of the doctors to give good medical care, to know what to do for a sick worker, but they do not trust the medical profession to handle the financial details of rendering such services, and they propose to take that away and by law. He boasted that the A.F. of L. had largely written the Wagner-Murray-Dingell Bill and they were going to see that it was enacted into law. The considered program of the union is to regiment medicine. They demand to be heard when their wages are in dispute, but deny the medical profession the same right.

Has the A.F. of L. read about the recent troubles the Veterans Administration ran into in attempting to provide medical care of the veterans in that assay into political medicine? Civilian medical service came to the rescue. How about the greatest attempt to give medical services to fifteen million military men? Were the doctors' services used to anywhere near the efficiency shown by civilian doctors during the same emergency?

These are two examples of "scientific confusion" in an attempt to render medical services by political methods. Do the American people want to extend that to the whole nation? We hope the elements who are asking for this political travesty will not be sorry when this confusion strikes. It will hit them, too, you know!

WAGNER-MURRAY-DINGELL— A SERVICEMAN'S VIEW*

THE WAGNER-MURRAY-DINGELL Bill is a legislative answer to an indictment of American Medicine. It was conceived by the social planners on the assumption that the government, using the

*This editorial was written by a returned serviceman known for his deep and medically economic thinking. Obviously his name cannot be signed to it.—Editor.

same physicians who now operate as individuals, can, by superior administration and by government financing, provide for the people of this country a better grade of medical care and a better distribution of medical care than now exist.

In drawing up their bill of complaint against the existing order, it was entirely proper that the proposers of this measure take cognizance of any failure on the part of physicians to provide for the health of the citizenry. The record of American Medicine has accordingly, and properly, been laid bare to the scrutiny of all who care to see. For good measure, the results of defects in our nation's housing program, faults of rural sanitation, and failures of our civilian economy have by some obscure process of reasoning been added to the alleged sins of the private physicians. All of these things are advanced as reasons why the government should administer medical practice.

But the government also has a record in the field of medicine. Federal and State agencies have been in the business of providing for the health of a large number of our citizens for some time. Since the advocates of government medicine base their proposal on the assumption that the government can do a better job than is being done, it might be well to inquire how well the government has performed in the provision of medical care in the past.

We could, for instance, look into the record of the Veterans Administration, the EMIC, or various state hospitals for the care of the insane. But let us observe a recent and extensive government excursion into the practice of medicine, the administration of the Medical Corps of the U. S. Army.

Before the expansion of the Medical Department in the late war, the Medical Corps became a part of the service forces. This placed medical professional service under lay control, a situation analogous to the proposal in the Wagner-Murray-Dingell Bill.

The results of this reorganization are well known, not only to physicians lately in the army, but also to thousands of patients who had ample opportunity to observe what happens when doctors take orders from laymen. The professional achievements of Army Medicine were, of course, splendid. The Surgeon General has recently given full credit for this accomplishment to the American civilian physicians who largely officered the Medical Corps, and to the superb and devoted enlisted personnel

who did a large share of the work. But what did the lay control of Army Medical Administration accomplish? The following is but a partial list of their triumphs. It might be extended indefinitely.

Administration by the Service of Supply produced more "spit and polish" in the medical units than formerly existed.

It provided a pool of enlisted manpower which could be raided by other branches whenever they thought a raid expedient. On the eve of at least one invasion, hospitals were called upon to send enlisted men, who had been laboriously trained to do certain essential medical jobs, to act as cooks to certain field units.

In the Zone of the Interior, it introduced the Army medic to bureaucracy in full bloom. There was the Civil Service employe in hospitals who frequently did as little work as possible in an eight-hour day; laid off whenever the fancy struck him, was impartially impudent to ward officer and patient, collected more than double the pay of the enlisted men and women who did most of the work, and was practically undischageable. There were, of course, many devoted and efficient civilians, but they had their troubles. If they did their work so efficiently that they could dispense with assistants, they were in danger of having their pay cut because of the rule, "the more people you supervise, the more pay you get."

Then there was the War Manpower Board. The representatives of that commission were all laymen who, armed with a document called a "yardstick," descended on medical installations and decreed that a hospital was a hospital and a ward was a ward whether the hospital or ward had medical patients or paraplegics, and that any ward, so the yardstick said, should have the same number of duty personnel. These administrators also evolved the theory that a "body is a body" and that a decrepit old man who worked forty hours a week should turn out as much work as a husky soldier who worked seventy-two hours.

Then there was the Control Officer, also a layman, who decided how medical records should be kept, and who evolved new "simplified" forms for doctors to execute. This officer also did time studies on various hospital procedures. While he never quite dared to set time limits for operative procedures, he cast covetous eyes in that direction.

We must not forget good old politics. That also went along with lay control of army medical practice. Those things that get the votes were

not forgotten, and so a nurse who supervised some seventy-five nurses suddenly became eligible for the same rank as the Chief of Surgical Service who had the responsibility of all surgery and all surgical patients in the hospital; and the newest WAC who had just completed her training as a medical technician might well outrank the enlisted man who taught her.

These are things which happened to medical practice in the army when it was placed under lay administrative control. This is the record of one government adventure in providing medical care. It should serve as a warning to physician and patient alike. *Under lay control, one third of the physicians in this country were able to give excellent care to the most fit one-twelfth of the population*, largely because they overcame the obstacles an inept lay administrative control placed in their path.

WE ARE PROGRESSING

LATELY WE HAVE extensively opposed the Wagner-Murray-Dingell Bill. We still believe that most progress can be made by offering some concrete substitute. The general thinking of medical leaders, the trend of editorial opinion and public relations are gradually tending to a definite medical program. For several months we have published "The Program of Health Legislation Beneficial to the Public" as adopted by the Conference of Presidents and other Officers of State Medical Associations and approved in principle by the House of Delegates of the American Medical Association.

The Council on Medical Service and Public Relations of the American Medical Association is working. Michigan has loaned Mr. Jay C. Ketchum the Executive Director of Michigan Medical Service, to aid in the cause, and he is visiting one state after another with his message.

Senators Taft of Ohio, Ball of Minnesota and Smith of New Jersey have introduced a bill as a substitute for the Wagner-Murray-Dingell Bill which embodies most of the principles we have advocated. Their bill is comprehensive, does not invade state rights, brings all federal health activities under a national health agency headed by a doctor of medicine with Cabinet status, and authorizes the use of voluntary health insurance. The Senators call their proposal "an American plan based on assistance to the needy, liberty to the individual, and a free medical profession."

And our publicity is improving. *Collier's Weekly* on May 11, 1946, published a five-page color-illustrated article lauding Michigan and Michigan Medical Service. It says Michigan's service to the veterans by their own home doctors is working and may be an answer to compulsory state medicine.

The resolution passed by our Council on January 29, 1945, and formulated into a statement of principles, which led to three Conferences of State Medical Society presidents, 17 in Detroit, 10 in Denver and 42 in Chicago, gathers force and power. Our medical public works have finally "made" a national magazine with an outstanding first for Michigan: Veterans' care by their own home doctors."

We believe a satisfactory national health program is in the making, with Senator Taft in the lead.

THE TAFT-BALL-SMITH BILL

AT LAST a concrete and definite effort has been made to furnish a national health program and preserve the independent action of the medical profession. Senators Taft of Ohio, Ball of Minnesota and Smith of New Jersey have introduced a Health Bill to co-ordinate the health function of the federal government in a single agency. The first and most important consideration is to provide adequate and essential health service to the people of the United States. This has been the motive in other measures suggested, the last several going under the name of Wagner, Murray and Dingell, but these have attempted to make the recipient of health service dependent on government dole. They have tried to make the whole matter a government service, the same as police protection, fire protection, et cetera. They are trying to frustrate the fundamental urge of the

American pioneer to hew out for himself the things he needed.

The medical profession has sponsored the most of public health, and of health and medical services that could be given, but in doing so endeavors to preserve the independent patient-physician relationship, the right of the practitioner to work where he wishes, and do the kind of work he chooses. Senator Taft and his team have caught the idea, have provided a plan that embodies the principles and theories that have dominated the thought of medicine, and have given us a bill that not only supplies the needs of the people, but which we can enthusiastically support without the fear of a great bureaucracy that will tell our patients how much medicine they may have, when, and from whom.

The sponsors of the bill have made no statement, but the bill incorporates the "Program of Health Legislation Beneficial to the People" as adopted by the Conference of Presidents and Other Officers of State Medical Societies.

ON THE RUN . . .

Quinidine sulphate is effective for paroxysmal auricular fibrillation and/or ventricular premature beats when these are neurogenic.

* * *

The physician who knows what is wrong with the patient and has an effective remedy for it can cut the cackle.

* * *

Tissue necrosis that follows solid freezing is due to vascular deficiency induced by blocking of blood vessels with red cells.

* * *

Artificially fed infants show a high coliform content in the bowel rare in the breast-fed; which accounts for much greater frequency and severity of diarrhea in the former.

—Selected by W. S. REVENO, M.D.

WHAT IT TAKES TO BE A DOCTOR OF MEDICINE

1. Four Years of High School
2. Two Years of College (including Physics, Chemistry, and Biology)
3. Four years in a Medical College
4. One Year's Internship in a Hospital
5. A Knowledge of the Human Body: Its Normal Structures, Functions and Governing Laws
6. A Knowledge of All Common Diseases in Order to Know What Disease is Present
7. A Knowledge of Effective Remedial Agents: Ability to Apply the One Most Needed.

THESE MINIMUM ESSENTIALS SHOULD BE POSSESSED BY
ALL WHO TREAT THE SICK

Michigan State Medical Society

Past Presidents 1866-1945



- | | |
|----------------------------------------------------|----------------------------------------|
| 1866—*C. M. Stockwell, Port Huron | 1903—*Wm. F. Breakey, Ann Arbor |
| 1867—*J. H. Jerome, Saginaw | 1904—*B. D. Harison, Sault Ste. Marie |
| 1868—*Wm. H. DeCamp, Grand Rapids | 1905—*David Inglis, Detroit |
| 1869—*Richard Inglis, Detroit | 1906—*Charles B. Stockwell, Port Huron |
| 1870—*I. H. Bartholomew, Lansing | 1907—*Hermon Ostrander, Kalamazoo |
| 1871—*H. O. Hitchcock, Kalamazoo | 1908—*A. F. Lawbaugh, Calumet |
| 1872—*Alonzo B. Palmer, Ann Arbor | 1909—*J. H. Carstens, Detroit |
| 1873—*E. W. Jenk, Detroit | 1910—*C. B. Burr, Flint |
| 1874—*R. C. Kedzie, Lansing | 1911—*D. Emmett Welsh, Grand Rapids |
| 1875—*Wm. Brodie, Detroit | 1912—*Wm. H. Sawyer, Hillsdale |
| 1876—*Abram Sager, Ann Arbor | 1913—*Guy L. Kiefer, Detroit |
| 1877—*Foster Pratt, Kalamazoo | 1914—*Reuben Peterson, Ann Arbor |
| 1878—*Ed. Cox, Battle Creek | 1915—*A. W. Hornbogen, Marquette |
| 1879—*George K. Johnson, Grand Rapids | 1916—*Andrew P. Biddle, Detroit |
| 1880—*J. R. Thomas, Bay City | 1917—*Andrew P. Biddle, Detroit |
| 1881—*J. H. Jerome, Saginaw | 1918—Arthur M. Hume, Owosso |
| 1882—*Geo. W. Topping, DeWitt | 1919—*Charles H. Baker, Bay City |
| 1883—*A. F. Whelan, Hillsdale | 1920—*Angus McLean, Detroit |
| 1884—*Donald Maclean, Detroit | 1921—*Wm. J. Kay, Lapeer |
| 1885—*E. P. Christian, Wyandotte | 1922—*W. T. Dodge, Big Rapids |
| 1886—*Charles Shepard, Grand Rapids | 1923—*Guy L. Connor, Detroit |
| 1887—*T. A. McGraw, Detroit | 1924—*C. C. Clancy, Port Huron |
| 1888—*S. S. French, Battle Creek | 1925—*Cyrenus G. Darling, Ann Arbor |
| 1889—*G. E. Frothingham, Detroit | 1926—J. B. Jackson, Kalamazoo |
| 1890—*L. W. Bliss, Saginaw | 1927—Herbert E. Randall, Flint |
| 1891—*George E. Ranney, Lansing | 1928—Louis J. Hirschman, Detroit |
| 1892—*Charles J. Lundy (died before taking office) | 1929—J. D. Brook, Grandville |
| *Gilbert V. Chamberlain, Flint, Acting President | 1930—*Ray C. Stone, Battle Creek |
| 1893—*Eugene Boise, Grand Rapids | 1931—*Carl F. Moll, Flint |
| 1894—*Henry O. Walker, Detroit | 1932—J. Milton Robb, Detroit |
| 1895—*Victor C. Vaughan, Ann Arbor | 1933—*George LeFevre, Muskegon |
| 1896—*Hugh McColl, Lapeer | 1934—*R. R. Smith, Grand Rapids |
| 1897—*Joseph B. Griswold, Grand Rapids | 1935—Grover C. Penberthy, Detroit |
| 1898—*Ernest L. Shurly, Detroit | 1936—Henry E. Perry, Newberry |
| 1899—*A. W. Alvord, Battle Creek | 1937—Henry Cook, Flint |
| 1900—*P. D. Patterson, Charlotte | 1938—Henry A. Luce, Detroit |
| 1901—*Leartus Connor, Detroit | 1939—Burton R. Corbus, Grand Rapids |
| 1902—*A. E. Bulson, Jackson | 1940—Paul R. Urmston, Bay City |
| *Deceased. | 1941—Henry R. Carstens, Detroit |
| | 1942—H. H. Cummings, Ann Arbor |
| | 1943—C. R. Keyport, Grayling |
| | 1944—A. S. Brunk, Detroit |

THE 81st ANNUAL SESSION MICHIGAN STATE MEDICAL SOCIETY



E. F. SLADEK, M.D.
Traverse City
Chairman, Council



R. S. MORRISH, M.D.
Flint
President



P. L. LEDWIDGE, M.D.
Detroit
Speaker

OFFICIAL CALL

The Michigan State Medical Society will convene in Annual Session in Detroit, Michigan, on September 22, 23, 24, 25, 26 and 27, 1946. The provisions of the Constitution and By-Laws and the Official Program will govern the deliberations.

R. S. MORRISH, M.D.
President

E. F. SLADEK, M.D.
Council Chairman

P. L. LEDWIDGE, M.D.
Speaker

J. S. DETAR, M.D.
Vice Speaker

Attest:

L. FERNALD FOSTER, M.D.
Secretary



L. FERNALD FOSTER, M.D.
Bay City
Secretary



JOHN S. DETAR, M.D.
Milan
Vice Speaker

Three-Day Session of House of Delegates September 22-23-24, 1946

The 1946 House of Delegates of the Michigan State Medical Society will hold a three-day session beginning Sunday, September 22 at 8:00 p.m. The business of the House will be transacted in the English Room on Sunday and Monday; and on Tuesday in the Ballroom of the Book-Cadillac Hotel, Detroit.

The House also will meet Monday, September 23, at 10:00 a.m. and again on Tuesday, September 24 at 10:00 a.m. and 8:00 p.m. The intervals

between meetings of the House of Delegates have been spaced to permit the reference committees ample time to transact all business referred to them. If the business warrants an additional meeting, it will be held Monday evening at 8:00 p.m.

Seating of Delegates

"Any Delegate-Elect not present to be seated at the hour of call of the First Session may be replaced by an accredited alternate next on the list as certified by the Secretary of the County Medical Society involved."

—MSMS By-Laws, Chapter 3, Section 3.

OUTLINE OF 1946 GENERAL ASSEMBLY SPEAKERS

80th Annual Session, Michigan State Medical Society

Detroit, September, 1946

	Wednesday September 25, 1946	Thursday September 26, 1946	Friday September 27, 1946
A.M. 9:00-9:25	Medicine EDGAR V. ALLEN, M.D. Rochester, Minnesota	Surgery R. B. CATTELL, M.D. Boston, Mass.	Gynecology EMIL NOVAK, M.D. Baltimore, Maryland
9:25-9:50	Surgery F. W. RANKIN, M.D. Lexington, Ky.	Medicine (Psychiatry) A. H. RUGGLES, M.D. Providence, R. I.	Medicine J. G. MILLER, M.D. Philadelphia, Pa.
9:50-10:35	INTERMISSION TO VIEW EXHIBITS	INTERMISSION TO VIEW EXHIBITS	INTERMISSION TO VIEW EXHIBITS
10:35-11:00	Dermatology F. E. SENEAR, M.D. Chicago, Ill.	General Practice F. D. MURPHY, M.D. Milwaukee, Wisc.	Pediatrics H. E. ALEXANDER, M.D. New York, N. Y.
11:00-11:25	Obstetrics F. B. CARTER, M.D. Durham, N. C.	Pediatrics A. M. BUTLER, M.D. Boston, Mass.	Surgery R. R. GRAHAM, M.D. Toronto, Canada
11:25-12 M	INTERMISSION TO VIEW EXHIBITS	INTERMISSION TO VIEW EXHIBITS	INTERMISSION TO VIEW EXHIBITS
P.M. 12:00-1:30	THREE SECTION MEETINGS Otolaryngology Dermatology Syphilology	FOUR SECTION MEETINGS Ophthalmology General Medicine Surgery Anesthesia	THREE SECTION MEETINGS Pediatrics Gynecology and Obstetrics Medicine
1:40-2:05	Medicine F. M. RACKEMANN, M.D. Boston, Mass.	Surgery GEORGE CRILE, JR., M.D. Cleveland, Ohio	Syphilology C. R. REIN, M.D. New York, N. Y.
2:05-2:30	Radiology ROSS GOLDEN, M.D. New York, N. Y.	Anesthesia R. T. KNIGHT, M.D. Minneapolis, Minn.	Pediatrics PHILIP LEVINE, M.D. Linden, N. J.
2:30-3:15	INTERMISSION TO VIEW EXHIBITS	INTERMISSION TO VIEW EXHIBITS	FINAL INTERMISSION TO VIEW EXHIBITS
3:15-3:40	Otolaryngology L. H. CLERF, M.D. Philadelphia, Pa.	Ophthalmology E. B. SPAETH, M.D. Philadelphia, Pa.	Medicine E. H. RYNEARSON, M.D. Rochester, Minnesota
3:40-4:05	General Practice S. A. WILKINSON, M.D. Boston, Mass.	Obstetrics N. J. EASTMAN, M.D. Baltimore, Maryland	Surgery C. W. MAYO, M.D. Rochester, Minn.
4:15-5:15	DISCUSSION CONFERENCES WITH GUEST ESSAYISTS	DISCUSSION CONFERENCES WITH GUEST ESSAYISTS	DISCUSSION CONFERENCES WITH GUEST ESSAYISTS
5:15-6:00	INTERMISSION TO VIEW EXHIBITS	INTERMISSION TO VIEW EXHIBITS	END
8:30-10:00	OFFICERS' NIGHT BIDDLE ORATION	STATE SOCIETY NIGHT	OF CONVENTION

House of Delegates --- 1946

English Room, Book-Cadillac Hotel, Detroit

ORDER OF BUSINESS*

SUNDAY, SEPTEMBER 22

8:00 p.m. E.S.T.—First Meeting

1. Call to order by Speaker
2. Report of Committee on Credentials
3. Roll Call
4. Appointment of Reference Committees:
 - (a) On Officers' Reports
 - (b) On Reports of The Council
 - (c) On Reports of Standing Committees
 - (d) On Reports of Special Committees
 - (e) On Amendments to Constitution and By-Laws
 - (f) On Resolutions
5. Speakers' Address—P. L. Ledwidge, M.D., Detroit
6. President's Address—R. S. Morrish, M.D., Flint
7. Annual Report of The Council—E. F. Sladek, M.D., Traverse City, Chairman
8. Report of Delegates to American Medical Association—Henry A. Luce, M.D., Detroit, Chairman
9. Resolutions**
10. Reports of Standing Committees:
 - (a) Legislative Committee
 - (b) Committee on Distribution of Medical Care
 - (c) Representatives to Joint Committee on Health Education
 - (d) Medical-legal Committee
 - (e) Preventive Medicine Committee
 - Cancer
 - Maternal Health
 - Venereal Disease Control
 - Tuberculosis Control
 - Industrial Health
 - Mental Hygiene
 - Child Welfare
 - Iodized Salt
 - Heart and Degenerative Diseases
 - (f) Committee on Postgraduate Medical Education
 - (g) Committee on Public Relations
 - (h) Committee on Ethics
11. Reports of Special Committees:
 - (a) Committee on Nurses' Training Schools
 - (b) Conference Committee on Precicensure Medical Education
 - (c) Radio Committee (scientific)
 - (d) Advisory Committee to Woman's Auxiliary
 - (e) Scientific Work Committee (in Council's Report)
 - (f) Professional Liaison Committee
 - (g) Beaumont Memorial Committee

*See the Constitution, Article IV, and the By-Laws, Chapter 3, on "House of Delegates."

**All Resolutions, special reports, and new business shall be presented in triplicate (By-Laws, Chapter 3, Section 7-n).

JUNE, 1946

- (h) Committee on Procurement and Assignment of M.D.s
- (i) Michigan Foundation Committee
- (j) Joint Committee with State Bar of Michigan
- (k) Medical Veterans' Readjustment Program (in Council's Report)
- (l) Special Committee on Radio
- (m) Postwar Education Committee
- (n) Rheumatic Fever Control Committee
- (o) Contact Committee with Association of Welfare Boards and Boards of Supervisors

MONDAY, SEPTEMBER 23

10:00 a.m. E.S.T.—Second Meeting

12. Supplementary Report of Committee on Credentials
13. Roll Call
14. Unfinished business
15. New Business†
16. Reports of Reference Committees:
 - (a) On Officers' Reports
 - (b) On Reports of The Council
 - (c) On Reports of Standing Committees
 - (d) On Reports of Special Committees
 - (e) On Amendments to Constitution and By-Laws
 - (f) On Resolutions

Recess

TUESDAY, SEPTEMBER 24

Ballroom, Book-Cadillac Hotel

10:00 a.m. E.S.T.—Third Meeting

17. Supplementary Report of Committee on Credentials
18. Roll Call
19. Unfinished Business
20. New Business
21. Supplementary Reports of Reference Committees:
 - (a) On Officers' Reports
 - (b) On Reports of The Council
 - (c) On Reports of Standing Committees
 - (d) On Reports of Special Committees
 - (e) On Amendments to Constitution and By-Laws
 - (f) On Resolutions

Recess

TUESDAY, SEPTEMBER 24

8:00 p.m. E.S.T.—Fourth Meeting

22. Supplementary Report of Committee on Credentials
23. Roll Call
24. Unfinished Business

†All Resolutions, special reports, and new business shall be presented in triplicate (By-Laws, Chapter 3, Section 7-n).

HOUSE OF DELEGATES

25. **Supplementary Report of The Council**
26. **Supplementary Report of Reference Committees**
27. **Elections**
 - (a) Councilors
 - 1st District—C. E. Umphrey, M.D., Detroit—Incumbent
 - 4th District—R. J. Hubbell, M.D., Incumbent
 - 5th District—A. B. Smith, M.D., Grand Rapids—Incumbent
 - 6th District—R. C. Pochert, M.D., Owosso—Incumbent
 - (b) Delegates to American Medical Association
 - Henry A. Luce, M.D., Detroit—Incumbent

- T. K. Gruber, M.D., Eloise—Incumbent
- C. R. Keyport, M.D., Grayling—Incumbent
- (c) Alternate delegates to American Medical Association
 - R. H. Denham, M.D., Grand Rapids—Incumbent
 - W. B. Barrett, M.D., Detroit—Incumbent
 - C. S. Gorsline, M.D., Battle Creek—Incumbent
- (d) President-Elect
- (e) Speaker of House of Delegates
- (f) Vice-Speaker of House of Delegates

Adjournment

DELEGATES TO MSMS HOUSE OF DELEGATES, 1946

Names of Alternates Appear in Italics

Officers

- P. L. Ledwidge, M.D.,
Detroit, Speaker
J. S. DeTar, M.D.,
Milan, Vice Speaker
L. Fernald Foster, M.D.,
Bay City, Secretary
A. S. BRUNK, M.D.,
Detroit, Immediate Past President

Allegan

- E. B. Johnson, M.D., Allegan
H. J. Stuck, M.D., Allegan

Alpena-Alcona-Presque Isle

- W. E. Nesbitt, M.D., Professional Bldg., Alpena
F. J. O'Donnell, M.D., State St., Alpena

Barry

- C. A. E. Lund, M.D., Middleville
H. S. Wedel, M.D., Hastings

Bay-Arenac-Gladwin-Iosco

- R. C. Perkins, M.D., Bay City
W. S. Stinson, M.D., Bay City
T. G. Wilson, M.D., Bay City
K. A. Alcorn, M.D., Bay City

Berrien

- D. W. Thorup, M.D., Benton Harbor
D. M. Richmond, M.D., St. Joseph

Branch

- R. L. Wade, M.D., Coldwater
H. J. Meier, M.D., Coldwater

Calhoun

- B. G. Holton, M.D., 815 Security Bank Bldg., Battle Creek
C. W. Brainard, M.D., Leila Post Montgomery Hospital, Battle Creek
L. P. Shipp, M.D., 1414 Security Bank, Battle Creek
G. W. Slagle, M.D., 1206 Security Bank, Battle Creek

Cass

- S. L. Loupee, M.D., Dowagiac
J. K. Hickman, M.D., Dowagiac

Chippewa-Mackinac

- B. T. Montgomery, M.D., Sault Ste. Marie
Clayton Willison, M.D., Sault Ste. Marie

Clinton

- W. B. McWilliams, M.D., Maple Rapids
S. R. Russell, M.D., St. Johns

Delta-Schoolcraft

- A. S. Kitchen, M.D., Escanaba
A. H. Miller, M.D., Gladstone

Dickinson-Iron

- D. R. Smith, M.D., Iron Mountain
L. E. Irvine, M.D., Iron River

Eaton

- G. C. Stucky, M.D., Charlotte
P. B. Brown, M.D., Charlotte

Genesee

- A. H. Kretchmar, M.D., 608 1st National Bank Bldg., Flint
A. N. Thompson, M.D., 1121 First National Bank Bldg., Flint
A. C. Pfeifer, M.D., Mt. Morris
J. E. Livesay, M.D., 619 First National Bank Bldg., Flint
J. H. Curtin, M.D., 507 Citizens Bank Bldg., Flint
C. K. Stroup, M.D., 2002 E. Court, Flint
V. H. Morrissey, M.D., 101 Stockdale, Flint
F. W. Baske, M.D., 1217 Mott Foundation Bldg., Flint

Gogebic

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M. A. Gertz, M.D., Ironwood

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E. J. Bolan, M.D., Suttons Bay

Gratiot-Isabella-Clare

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J. L. Rottschaefer, M.D., Alma

Hillsdale

- L. W. Day, M.D., Jonesville
O. G. MacFarland, M.D., North Adams

Houghton-Baraga-Keweenaw

- R. J. McClure, M.D., Calumet
Alfred LaBine, M.D., Houghton

Huron

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W. B. Holdship, M.D., Ubly

Ingham

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L. G. Christain, M.D., 108 E. St. Joseph, Lansing
R. S. Breakey, M.D., 1221 Bk. of Lansing Bldg., Lansing
H. W. Wiley, M.D., 300 W. Ottawa, Lansing
J. O. Wetzel, M.D., 1912 Olds Tower, Lansing
Milton Shaw, M.D., 320 Townsend, Lansing

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E. P. Bunce, M.D., Trufant

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C. S. Clarke, M.D., 605 Dwight Bldg., Jackson
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John Van Schoick, M.D., Hanover

Kalamazoo

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L. W. Gerstner, M.D., 420 John, Kalamazoo

Kent

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Harry Liefers, M.D., Medical Arts Bldg., Grand Rapids
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A. V. Wenger, M.D., Loraine Bldg., Grand Rapids
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Torrance Reed, M.D., Ashton Bldg., Grand Rapids
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S. L. Moleski, M.D., Medical Arts Bldg., Grand Rapids
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Lapeer

D. J. O'Brien, M.D., Lapeer
H. B. Zemmer, M.D., Lapeer

Lenawee

H. H. Hammel, M.D., Tecumseh
E. T. Morden, M.D., Adrian

Livingston

H. L. Sigler, M.D., Howell
E. D. Finch, M.D., Howell

Luce

H. E. Perry, M.D., Newberry
W. R. Purmort, Jr., M.D., State Hospital, Newberry

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A. B. Bower, Armada

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E. A. Oakes, M.D., 401 River, Manistee
E. B. Miller, M.D., 425 River, Manistee

Marquette-Alger

R. A. Burke, M.D., Negaunee
W. A. Corcoran, M.D., Ishpeming

Mason

C. A. Paukstis, M.D., Ludington
R. C. Lintner, M.D., Ludington

Mecosta-Osceola-Lake

T. P. Treynor, M.D., Big Rapids
Paul Ivkovich, M.D., Reed City

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Menominee

K. C. Kerwell, M.D., Stephenson
H. T. Sethney, M.D., Menominee

Midland

H. H. Gay, M.D., c/o Dow Chemical Co., Midland
E. H. Meisel, M.D., Midland

Monroe

T. A. McDonald, M.D., 7 E. Front, Monroe
B. J. Fieldhouse, M.D., Ida

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L. E. Holly, M.D., N. 2nd St., Muskegon
T. J. Kane, M.D., 179 Strong Ave., Muskegon
C. L. Oden, M.D., Hackley Bank Bldg., Muskegon

Newaygo

J. W. O'Neil, M.D., White Cloud
T. R. Deur, M.D., Grant

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G. A. Wood, M.D., Onaway

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L. A. Farnham, M.D., 54 W. Huron, Pontiac
C. T. Ekelund, M.D., 906 Riker Bldg., Pontiac
T. H. Pauli, M.D., 206 Riker Bldg., Pontiac

Oceana

C. H. Flint, M.D., Hart

Ontonagon

S. H. Rubinfeld, Ontonagon
H. B. Hogue, M.D., Ewen

Ottawa

C. V. Costello, M.D., Holland
D. C. Bloemendal, M.D., Zeeland

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H. G. Kleekamp, M.D., 1005 Gratiot, Saginaw

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N. J. Ellis, M.D., Croswell

Shiawassee

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St. Clair

George Waters, M.D., 940 Military, Pt. Huron
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St. Joseph

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Tuscola

Harry Berman, M.D., Millington

Van Buren

W. R. Young, M.D., Lawton
R. W. Spalding, M.D., Gobles

Washtenaw

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H. P. Lynn, M.D., 23 N. Washington, Ypsilanti
J. S. DeTar, M.D., Milan
C. H. Ross, M.D., 715 N. University Ave., Ann Arbor
R. W. Teed, M.D., Ann Arbor
H. A. Towsley, M.D., Ann Arbor
H. A. Miller, M.D., Saline
C. H. Frye, M.D., Ann Arbor

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W. W. Babcock, M.D., 1054 Fisher Bldg., Detroit
J. J. Lightbody, M.D., 501 David Whitney Bldg., Detroit
T. K. Gruber, M.D., Eloise Hospital, Eloise
Douglas Donald, M.D., 1553 Woodward Ave., Detroit
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D. C. Somers, M.D., Detroit
H. B. Fenech, M.D., Detroit
W. P. Chester, M.D., Detroit
W. S. Gonne, M.D., Detroit
C. E. Lemmon, M.D., Detroit
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R. C. Connelly, M.D., Detroit
L. J. Gariepy, M.D., Detroit
H. L. Morris, M.D., Detroit
Carl Ratigan, M.D., Dearborn
W. G. Reid, M.D., Detroit
E. C. Texer, M.D., Detroit
V. N. Butler, M.D., Detroit
R. K. Johnson, M.D., Detroit
E. H. Lauppe, M.D., Detroit
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J. E. Croushore, M.D., Detroit
L. T. Henderson, M.D., Detroit
D. I. Sugar, M.D., Detroit
L. S. Fallis, M.D., Detroit
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W. A. Chipman, M.D., Detroit

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L. E. Showalter, M.D., Cadillac
C. E. Merritt, M.D., Manton

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(All meetings of the Reference Committees will be held in the Book-Cadillac Hotel, Detroit)

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William Bromme, M.D. Milton C. Darling, M.D.
P. H. Engle, M.D. C. W. Oakes, M.D.

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D. C. Eisele, M.D. C. W. Oakes, M.D.

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Frank Weiser, M.D. W. Stinson, M.D.
T. A. McDonald, M.D. C. A. Paukstis, M.D.

Amendments to Constitution and By-Laws

Parlor J

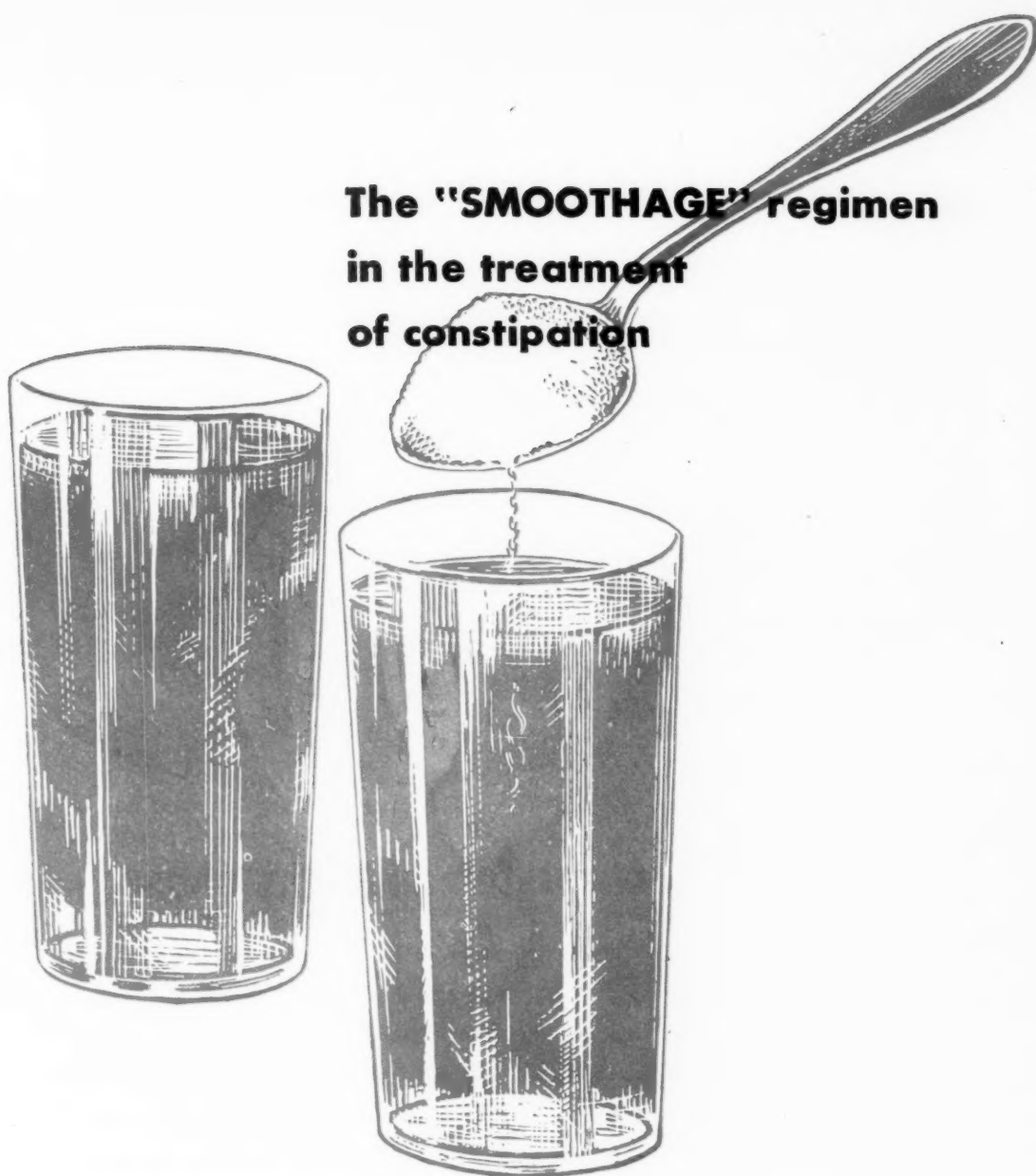
R. H. Holmes, M.D., Chairman
Warren Babcock, M.D. W. B. Cooksey, M.D.
R. S. Breakey, M.D. R. A. Springer, M.D.

Resolutions

Parlor K

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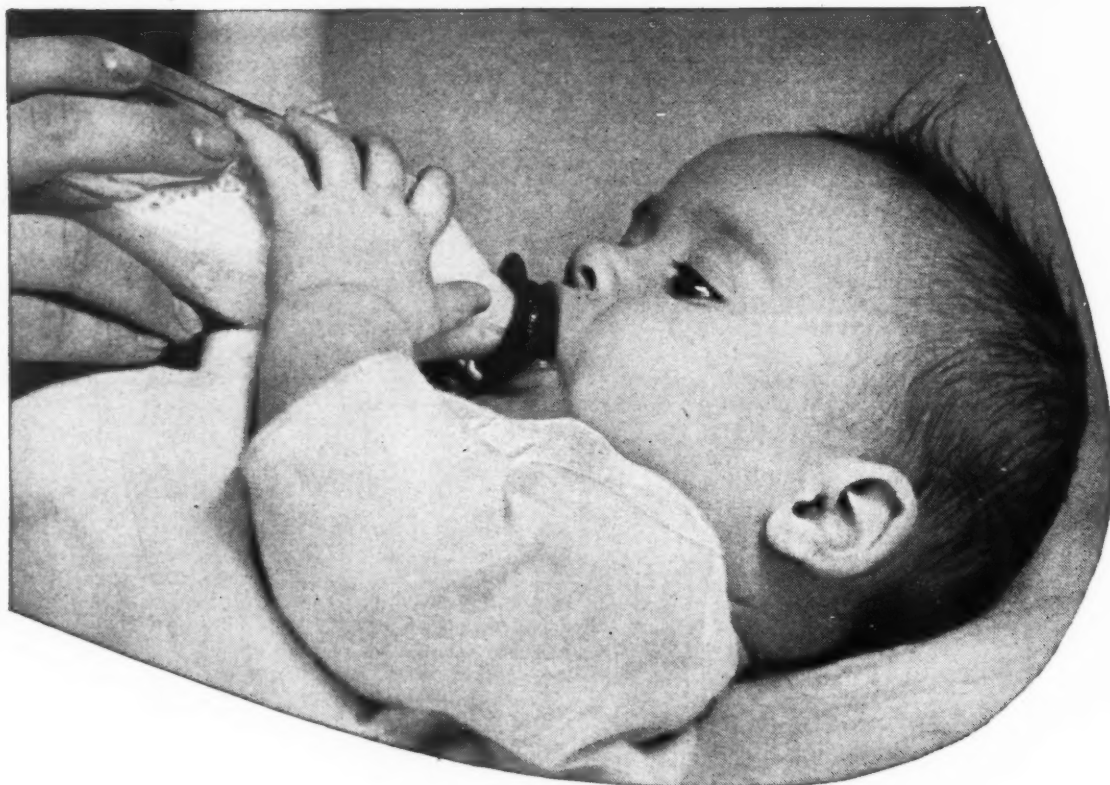
SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

JUNE, 1946

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795



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When pediatricians prescribe 'Dexin' brand High Dextrin Carbohydrate for their infant patients, the physicians are no longer awakened so frequently by frantic late-night phone calls. Because of the high dextrin content, 'Dexin' feedings tend to (1) diminish intestinal fermentation and the resultant colic and diarrhea and (2) promote the formation of soft, flocculent, easily digested curds.

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Composition—Dextrins 75% • Maltose 24% • Mineral Ash 0.25% • Moisture 0.75% • Available Carbohydrate 99% • 115 calories per ounce • 6 level packed tablespoonfuls equal 1 ounce • Containers of twelve ounces and three pounds • Accepted by the Council on Foods and Nutrition, American Medical Association.
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IS YOUR WILL OBSOLETE?

An obsolete will may deprive your family of those assurances for their future happiness which you so carefully planned. For that reason it is wise to review your will frequently in the light of the following questions:

- *Have births or deaths changed the list of your beneficiaries?*
- *Have your liquid assets kept pace with increased estate taxes?*
- *Has your estate materially increased or decreased?*
- *Has your Executor (if an individual) died, ceased to reside in Michigan, or has ill health or increased business pressure made doubtful the wisdom of continuing his appointment?*
- *Has the ratio of real estate to personal property changed materially?*
- *Have you entered a partnership or closed corporation?*

Your answers to these questions will suggest the importance of reviewing your Will immediately. At the same time, consider the advantages of naming Detroit Trust Company as your Executor and Trustee—for assured availability, group judgment and financial responsibility.

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Postgraduate Continuation Courses

Summer Quarter beginning July 8, 1946

These courses are open to all qualified individuals.
Veterans should make arrangements for tuition and books as provided by the GI Bill, with the Veterans' Counsellor at the College of Medicine.
Registration for these courses should be completed with the Director of Graduate Medical Education, at the College of Medicine before July 6, 1946.

Basic Sciences

Anatomy

Regional Anatomy—College of Medicine Arranged.....\$40

Bacteriology

Newer Bactericidal Agents—College of Medicine—Monday 4-5.....\$10

Pharmacology

Physical Medicine—Grace Hospital—Thursday 1-5.....\$30

Seminar—College of Medicine—Friday 4-5.....\$10

Physiological Chemistry

Seminar—College of Medicine—Wednesday 4-5.....\$10

Clinical Specialties

Dermatology

Graduate Conference in Venereal Diseases—Social Hygiene Clinic—Thursday 3-4:30.....\$20

Seminar in Dermatology—Receiving Hospital—Wednesday 10-11:30.....\$10

Dermatologic Clinic and Conference (4 weeks—limited to 5)—Receiving Hospital
Monday 11-12; Wednesday 10-12; Friday 11-12.....\$10

Internal Medicine

Medical Pathological Conference—Receiving Hospital—Friday 11-12.....\$10

Medical Pathological Conference—Wayne County General—Thursday 11-12.....\$10

Therapeutic Conference } —Receiving Hospital—Thursday 11-12 }
Hematology Clinic } —Receiving Hospital—Thursday 11-12 }

Medical X-ray Conference—Receiving Hospital—Tuesday 11-12.....\$10

Medical X-ray Conference—Wayne County General—Friday 1-2.....\$10

Gastroenterology—Receiving Hospital—Wednesday 1-2.....\$10

Diagnostic Conference—Wayne County General—Wednesday 4-5.....\$10

Seminar in Internal Medicine—Wayne County General—Tuesday 4-5.....\$10

Electrocardiography—Wayne County General—Friday 11-12.....\$10

Neurology and Psychiatry

Neurologic Conference—Wayne County General—Tuesday 10-11.....\$10

Clinical Psychiatric Seminar—Wayne County General—Wednesday 2:30-4:30.....\$20

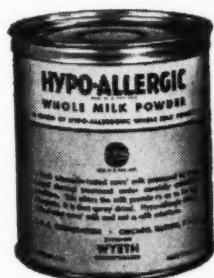
Radiology

Radiology Conference—Affiliated Hospitals—Monday 6:30-8.....\$20



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Altered Protein



HYPO-ALLERGIC* WHOLE MILK

Particularly suited for infants and children allergic to cow's milk protein, Hypo-Allergic Milk has been rendered less allergenic by means of prolonged thermal processing. When reconstituted with water it is used in the same proportion as whole cows' milk.

POWDER—1 lb. tins

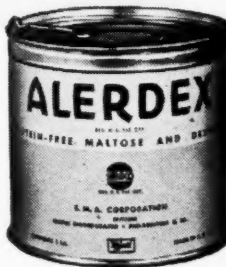
LIQUID 14½ oz. tins

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Protein-free Maltose and Dextrins

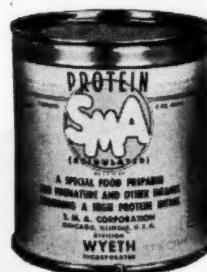
An all-around milk modifier especially useful in the hypo-allergenic milk diet of the infant sensitive to proteins, Alerdex is prepared from noncereal starch by a special procedure to eliminate every trace of protein.

POWDER—16 oz. tins



No Protein

High Protein



PROTEIN S-M-A* (Acidulated)

The easily digested curd and liberal vitamin content makes Protein S-M-A a valuable aid in the management of premature and undernourished newborn infants. Also indicated in infant diarrhea and other conditions where a high protein intake is required.

POWDER—8 oz. tins

Use one of these Special
Infant Foods

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JUNE, 1946

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799



Subject to change without notice

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1. Freed, S. C., and Greenhill, J. P. (1941), *J. Clin. Endocrinol.*, 1:983, December.

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EASY FOR PATIENTS TO STICK TO!

No matter how sound the diet, if a patient won't follow it, it won't work.

But you *can* plan reducing diets acceptable both to you and the patient. You'll find Knox Gelatine a big help here.

Knox Gelatine is all protein, no sugar.

Knox salads and desserts add variety and interest to restricted diets. Many contain high residue, low-calorie foods and so help stave off hunger.

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ALL PROTEIN, NO SUGAR



Michigan's Department of Health

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TEN LEADING CAUSES OF DEATH IN MICHIGAN BY AGE-GROUPS

1945					1935				
Age-group	Cause	Total	Male	Female	Cause	Total	Male	Female	
Under 1	All Causes	4,007	2,239	1,768	All Causes	4,170	2,424	1,746	
	Premature birth	1,339	766	573	Premature birth	1,389	838	551	
	Congenital malformations	743	397	346	Pneumonia	602	338	264	
	Pneumonia	453	250	203	Congenital malformations	554	305	249	
	Injury at birth	349	202	147	Injury at birth	292	173	119	
	Other diseases peculiar to the first year of life	319	178	141	Other diseases peculiar to the first year of life	276	161	115	
	Diarrhea, enteritis (under 2 years)	251	145	106	Diarrhea, enteritis (under 2 years)	184	96	88	
	Accidents	97	49	48	Congenital debility	147	89	58	
	Diseases of the thymus gland	77	40	37	Diseases of the thymus gland	105	67	38	
	Congenital debility	52	30	22	Whooping cough	89	42	47	
	Influenza	36	19	17	Influenza	73	47	26	
1-4	All Causes	764	433	331	All Causes	1,060	587	473	
	Accidents	209	128	81	Pneumonia	232	136	96	
	Pneumonia	106	64	42	Accidents	161	88	73	
	Congenital malformations	67	35	32	Measles	94	49	45	
	Tuberculosis	46	19	27	Tuberculosis	68	37	31	
	Influenza	29	17	12	Whooping cough	40	15	25	
	Cancer	25	11	14	Influenza	37	17	20	
	Leukemias and aleukemias	21	11	10	Scarlet fever	33	18	15	
	Diphtheria	19	11	8	Diarrhea, enteritis (under 2 years)	32	19	13	
	Other diseases of the nervous system	18	12	6	Congenital malformations	25	16	9	
	Appendicitis	12	5	7	Diarrhea, enteritis (2 years and over)	22	13	9	
	Diarrhea, enteritis (2 years and over)	12	5	7					
5-14	All Causes	688	428	260	All Causes	1,266	722	544	
	Accidents	287	219	68	Accidents	302	224	78	
	Pneumonia	34	17	17	Appendicitis	106	60	46	
	Tuberculosis	31	7	24	Pneumonia	105	52	53	
	Acute rheumatic diseases	28	15	13	Tuberculosis	79	34	45	
	Appendicitis	27	15	12	Heart disease	60	28	32	
	Cancer	25	17	8	Acute rheumatic fever	49	25	24	
	Congenital malformations	21	13	8	Measles	47	25	22	
	Disease of the buccal cavity, pharynx, tonsils and adnexa	18	6	12	Scarlet fever	37	27	10	
	Heart Disease	18	6	12	Nephritis	34	14	20	
					Disease of the mastoid process	30	16	14	
15-24	All Causes	1,265	687	578	All Causes	2,071	1,113	958	
	Accidents	359	274	85	Accidents	483	375	108	
	Tuberculosis	250	87	163	Tuberculosis	352	137	215	
	Heart disease	105	51	54	Pneumonia	159	102	57	
	Cancer	58	36	22	Heart disease	149	67	82	
	Maternal deaths	50	...	50	Maternal deaths	140	...	140	
	Nephritis	47	26	21	Appendicitis	139	89	50	
	Pneumonia	40	22	18	Suicide	62	41	21	
	Homicide	29	19	10	Nephritis	39	16	23	
	Suicide	27	20	7	Influenza	36	18	18	
	Appendicitis	26	12	14	Epilepsy	32	20	12	
25-44	All Causes	5,040	2,817	2,223	All Causes	7,022	4,039	2,983	
	Heart disease	973	602	371	Heart disease	934	554	380	
	Cancer	646	221	425	Accidents	876	733	143	
	Tuberculosis	630	379	251	Tuberculosis	838	508	330	
	Accidents	588	458	130	Pneumonia	822	581	241	
	Nephritis	227	114	113	Cancer	523	190	333	
	Pneumonia	188	117	71	Maternal deaths	293	...	293	
	Suicide	175	129	46	Nephritis	293	142	151	
	Apoplexy	168	74	94	Suicide	226	144	82	
	Maternal deaths	115	...	115	Appendicitis	205	132	73	
	Homicides	114	87	27	Apoplexy	172	81	91	
45-64	All Causes	16,020	10,029	5,991	All Causes	13,926	8,344	5,582	
	Heart disease	5,730	4,059	1,671	Heart disease	3,740	2,423	1,317	
	Cancer	3,021	1,472	1,549	Cancer	2,144	934	1,210	
	Apoplexy	1,405	676	729	Apoplexy	1,120	562	558	
	Nephritis	767	462	305	Pneumonia	935	681	254	
	Accidents	728	577	151	Accidents	896	702	194	
	Tuberculosis	588	494	94	Nephritis	832	453	379	
	Diabetes	559	184	375	Tuberculosis	532	393	139	
	Pneumonia	421	307	114	Diabetes	492	183	309	
	Syphilis	279	222	57	Suicide	280	232	48	
	Cirrhosis of the liver	262	180	82	Syphilis	194	152	42	
65 years and older	All Causes	25,827	13,752	12,075	All Causes	21,505	11,390	10,115	
	Heart disease	10,575	5,726	4,849	Heart disease	7,560	4,025	3,535	
	Apoplexy	3,533	1,720	1,813	Apoplexy	2,901	1,503	1,398	
	Cancer	3,367	1,787	1,580	Cancer	2,459	1,261	1,198	
	Nephritis	1,586	872	714	Nephritis	1,759	940	819	
	Accidents	1,163	605	558	Accidents	974	486	488	
	Arteriosclerosis	900	481	419	Pneumonia	943	521	422	
	Diabetes	877	294	583	Arteriosclerosis	819	437	382	
	Pneumonia	690	393	297	Diabetes	618	241	377	
	Senility	375	174	201	Senility	471	219	252	
	Diseases of the prostate	230	230	...	Diseases of the prostate	309	309	...	

(Turn to Page 806)

WHENEVER

Impaired Fat Digestion

MUST BE OVERCOME

Impairment of fat digestion implies more than loss of available caloric food energy to the organism. It involves the failure of absorption of the fat-soluble vitamins A, D, E, and K, together with the development of deficiency manifestations. Particularly severe is vitamin K deficiency with prolongation of the prothrombin clotting time and the consequent hemorrhagic diathesis.

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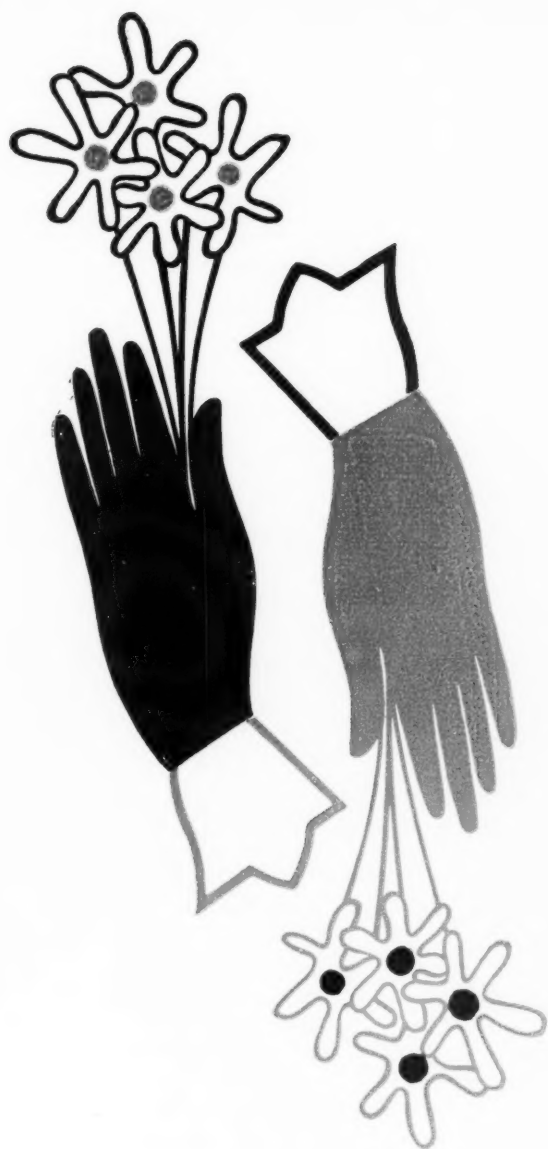


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phenolphthalein and an agar-gel.
Dispensed in bottles of
6, 10 and 16 fluidounces.*

'agarol'

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(Continued from Page 802)

DIPHThERIA ON INCREASE

Diphtheria rose to eighth place among the leading causes of death for children between the ages of one and five in Michigan in 1945.

Between January 1 and May 1 a total of 187 diphtheria cases was reported to the Michigan Department of Health. This is more than twice the number of cases for the same period of 1942, the year when diphtheria began to rise.

County	Cases of Diphtheria	County	Cases of Diphtheria
Baraga	1	Kent	1
Bay	3	Lake	1
Berrien	3	Lapeer	1
Calhoun	23	Lenawee	3
Eaton	1	Mecosta	1
Genesee	7	Monroe	1
Gogebic	9	Oakland	9
Houghton	6	Ontonagon	2
Ingham	3	Saginaw	4
Ionia	1	Sanilac	1
Jackson	1	St. Clair	26
Kalamazoo	7	Schoolcraft	2
Kalkaska	1	Tuscola	1
		Wayne	68

INCIDENCE OF COMMUNICABLE DISEASE

Disease	April 1946	April 1945	7 Year Median
Diphtheria	27	34	22
Gonorrhea	1029	920	588
Lobar Pneumonia	67	77	309
Measles	9794	705	2488
Meningococcic			
Meningitis	23	26	11
Pertussis	435	307	736
Poliomyelitis	2	6	1
Scarlet Fever	782	1090	1227
Syphilis	1571	1422	1148
Tuberculosis	411	489	509
Typhoid fever	9	4	6
Undulant fever	18	24	15
Smallpox	1	2	3

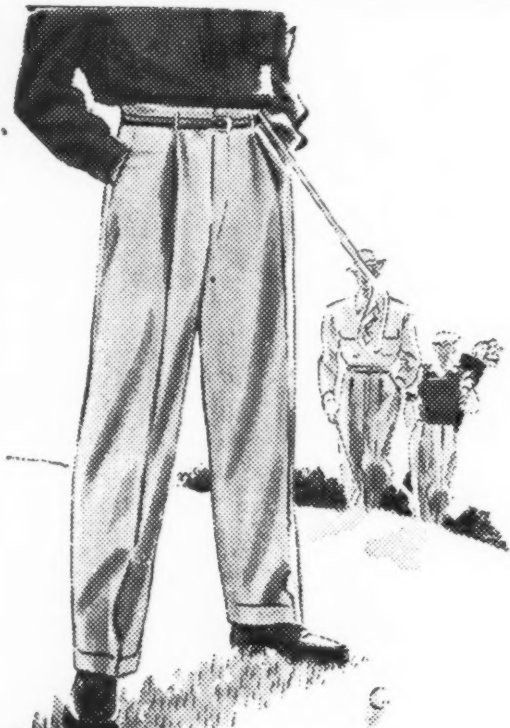
LENAWEE VOTES FOR HEALTH DEPARTMENT

Lenawee will become the seventieth county in Michigan to have the services of a full-time health department. This was decided by a 26 to 3 vote by the board of supervisors on April 11, 1946. The supervisors hope that the new health department will be in operation by September 1, 1946.

DOCTOR SMITH RESIGNS

Lillian Smith, M.D., for several years director of the Bureau of Maternal and Child Health of the Michigan Department of Health, has announced her resignation, effective July 1, 1946.

Goldie Corneliuson, M.D., Associate Director of the Bureau for the past four years, has been appointed director to succeed Doctor Smith.



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In keeping with these expressed opinions we continue to suggest that for the optimum in protection the physician prescribe the combined use of occlusive diaphragm and spermaticidal jelly.

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Competent observers report:

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"When no type of occlusive pessary can be fitted, or when the woman refuses to use one, the only other reliable method is the use of the condom. With proper technic and instruction this method is highly reliable but has many disadvantages which the diaphragm method overcomes."³

1. Clinic Reports: Planned Parenthood Services in the United States. Human Fertility 10: 25 (Mar.) 1945.
2. Dickinson, R.L.: Techniques of Conception Control. Baltimore, Williams and Wilkins Co., 1942.
3. Warner, M.P.: J.A.M.A. 115: 279 (July 27) 1940.



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J U N E , 1 9 4 6

Say you saw it in the Journal of the Michigan State Medical Society

What's What

W. W. Zuelzer, M.D., Detroit is the author of an original article "Folic Acid in Anemia" which appeared in JAMA of May 4, 1946.

* * *

The Saginaw County Medical Society and the Saginaw County Pharmaceutical Association held its annual "Druggists and Doctors Smoker" at Frankenmuth on April 11.

* * *

Bruce H. Douglas, M.D., Commissioner of Health, Detroit, recently was chosen a member of the Red Cross Advisory Board on Health Services. Congratulations, Doctor Douglas!

* * *

The University of Cincinnati has received a grant of \$1,000 from Winthrop Chemical Company, Inc., to support investigations on nutrition carried out under the direction of Tom D. Spies, M.D., in 1946.

* * *

The two Michigan representatives to the U. S. Senate Committee on Education and Labor hearing on the Wagner-Murray-Dingell Bill in Washington, D. C., were R. L. Novy, M.D., and J. C. Ketchum, Detroit, who testified on May 23.

Procurement and Assignment Service for Michigan closed its office as of April 1; all future correspondence regarding procurement and assignment cases is to be forwarded to the P. and A. S. office in Washington, D. C.

* * *

The American Congress of Physical Medicine will hold its Twenty-fourth Annual Scientific and Clinical Session September 4-5-6-7 at Hotel Pennsylvania, New York. For information and program address the Congress at 30 North Michigan Ave., Chicago 2, Illinois.

* * *

A Comp for JMSMS.—"We consider your JOURNAL one of the best printed of all the State Medical Society magazines, and only ask you to please try to keep up the good work, both in make-ready and the matching of colors and in positioning."—F. Atwater, Advertising Manager, Wyeth, Inc., Philadelphia.

* * *

Extemporaneous Public Debate.—"It is the sense of the Executive Committee of The Council that it is not compatible with the best interests and good public relations of the medical profession for its members to engage in Extemporaneous Public Debate on medical socio-

(Continued on page 812)



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812

(Continued from Page 810)

economics. This does not refer to presentation of the views of the medical profession on socio-economic subjects in other than debate form."—November 28, 1945.

* * *

British Labor's Social Plans.—It has been calculated that with the new bill, and on the assumption that not more than 5 per cent of the employable population will be unemployed on the average, the British Government will be taking about 24 per cent of the gross income of individuals in compulsory contributions for social security and other forms of social services.—*Insurance Economics Surveys*, March, 1946.

* * *

W. B. Harm, M.D., Detroit, was installed as President of the Wayne County Medical Society at its Annual Meeting of May 6. The ceremonies were in charge of Stanley W. Insley, M.D., retiring President. Clarence L. Candler, M.D., was chosen as President-Elect.

A highlight of the WCMS meeting was the story of Robert K. Whitely, M.D., who related his experience as a Jap prisoner of war for 44 months.

* * *

John W. Towey, M.D., of Powers, Michigan, Medical Superintendent of the Pinecrest Sanitarium for the last twenty-five years, has been appointed as Chief of the Tuberculosis Division for the Columbus branch office of the Veterans Administration. Dr. Towey will be in charge of all technical and administrative aspects of the tuberculosis program in Veterans Administration hospitals of Ohio, Michigan and Kentucky. Congratulations and all success, Dr. Towey!

* * *

The "Army-Navy Number" of the Oakland County Medical Society Bulletin appeared as the May, 1946, issue. A special cover of imitation red leather with gold printing and special insignia of the military services graced this handsome number of 34 pages. A photograph and biographical sketch of the 61 Oakland County physicians who served in the armed forces during the last war covered 14 pages of the special Army-Navy Number.

* * *

George J. Curry, M.D., Flint, is the author of an original article "The Role of An Approved Affiliate Hospital under the Program of Graduate Training in Surgery" published in the American College of Surgeons Bulletin, February, 1946.

* * *

John H. Law, M.D., Detroit, was installed as President of the Michigan Hospital Association at ceremonies held at the Tri-State Hospital meeting in Chicago on May 3. Doctor Law is Superintendent of Detroit's Grace Hospital. Congratulations!

* * *

"There is, I believe, too much of a tendency in Washington to want to manage the lives and activities of everyone, whether or not they want or need such federal

(Continued on Page 814)

JOUR. MSMS

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(Continued from Page 812)

supervision. Continuation and expansion of such policies can do naught but pile the national debt higher and higher and push us further and further from a balanced budget."

—Mr. Fred Bailey, Legislative Counsel for the National Grange, before Senate Committee on Education and Labor, May 3, 1946.

* * *

The Ionia-Montcalm County Medical Society heard Major A. D. Alguire and Mr. Lyman Smith of the Office of Veterans Affairs, State of Michigan, at its meeting of May 21, in Portland.

The representative of the Office of Veterans Affairs reported on their arrangements for the medical care of veterans for non-service connected disabilities, and answered questions relative to the over-all coverage of veterans by the State Office of Veterans Affairs.

* * *

The Penal Law of the State of New York has been amended to authorize dissection of the dead body of a human being and "whenever and so far as the husband, wife or next of kin of the deceased, being charged by law with the duty of burial, (a) may authorize dissection for the sole purpose of ascertaining the cause of death, or (b) may authorize dissection for any other purpose by written instrument which shall specify the purpose and extent of the dissection so authorized."

This information has been forwarded by the Eye-Bank for Sight Restoration, Inc.

* * *

Louis J. Hirschman, M.D., former president of the Michigan State Medical Society, was a guest speaker at the South Carolina Medical Association meeting May 1, 1946. In their announcement of the meeting they paid tribute: "Our guest speaker is a pioneer of unusual ability and one upon whom many honors have been heaped. These have been well earned by a long life devoted to teaching and writing in a field of surgery which he helped to make respectable and worthy of a place as a true specialty in Medicine. . . . He has written several books on ano-rectal diseases, and has published innumerable articles. He has done us distinct honor to attend our meeting and to be so generous with his time and talents."

* * *

The eastern half of the Tenth Council District held a meeting, under the Chairmanship of Councilor Fred H. Drummond, M.D., Kawkawlin, on April 18. Approximately 40 members of the Alpena-Alcona-Presque Isle County Medical Society and of the Bay-Arenac-Iosco County Medical Society met at the Alpena Golf Club for a pre-prandial hour and dinner, followed by a program in which MSMS President R. S. Morrish, M.D., Flint, spoke on "Medical Economics and Courses in this Subject."

L. Fernald Foster, M.D., Bay City, Secretary of the State Society, outlined "Better Medical Public Relations." Gordon Goodrich, Detroit, Assistant Director of Michi-

(Continued on Page 816)

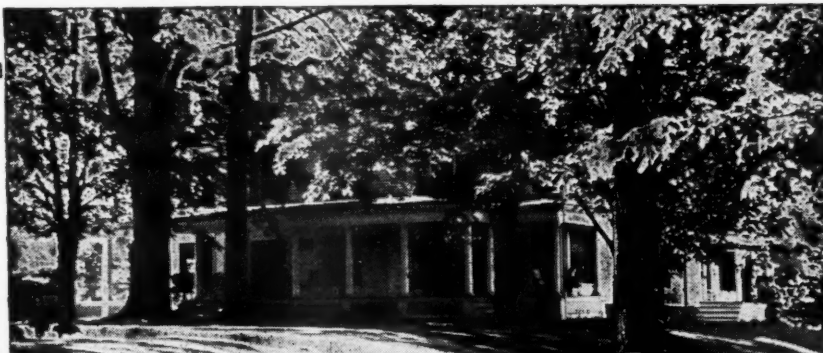
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1. Freund, J., and Thomson, K. J., Science, 101:468, 1945.

2. Cohn, A., Kornblith, B., Grunstein, I., Thomson, K. J., and Freund, J. (a) Proc. Soc. Exper. Biol. & Med., 59:145, 1945, (b) Venereal Diseases Information (U. S. Public Health Service), 1946, in press.

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(Continued from Page 814)

gan Medical Service, spoke on "Michigan's Plan for Home-Office Medical Care of Veterans."

A spirited general discussion followed, under the Chairmanship of J. A. Ramsey, M.D., President of the Alpena-Alcona-Presque Isle County Medical Society.

* * *

The Ghost Slayer.—Sen. Forrest C. Donnell last week revealed himself as an exorciser of ghost-writers, and Washington trembled at the threat to a comfortable tradition.

The Missourian opened his unorthodox attack as Secretary of Labor Lewis B. Schwellenbach concluded a twelve-page speech before the Senate Education and Labor Committee advocating passage of a health insurance bill. "Who wrote that speech?" Donnell asked. When the Secretary hedged, Donnell charged that Schwellenbach, relying solely on his "prestige as a member of the Cabinet," had made a speech on a subject "he knows nothing about." Despite Sen. Claude Pepper's protest that the Secretary was being questioned "like a criminal," the attack continued.

DONNELL: "Has the secretary read the testimony submitted by the Public Health Service to this Committee?"

SCHWELLENBACH: "No."

DONNELL (reading from Schwellenbach's speech): "I am sure you all must have been impressed, as I have been, with the testimony submitted by the Public Health Service to your committee."

SCHWELLENBACH (weakly): "Your criticism is absolutely right."

—*Newsweek*, May 13, 1946

* * *

Socialized Medicine in America.—To establish socialized medicine in America would be to place the health and welfare of the people in the hands of politicians. A co-operative health insurance program might be accepted by Congress but it is safe to say the majority of members do not want the CIO proposal. This is especially true following a showing by the Insurance Economics Society of America that 40,000,000 persons in America are already covered by voluntary health and accident policies—a five-fold increase since 1939—and at less cost than that which will be required if the Government takes over.

Congress was told this week that 400 companies now write health and accident insurance. Total premiums in 1944 were \$525 million for this class of business, exclusive of hospital service policies. In addition more than 5,000,000 people carry prepaid medical care programs, covering hospital and surgical bills. Several million others are covered by employer-sponsored plans in industry. Seventeen million others participate in the so-called Blue Cross Hospital plans. Consolidating all of these voluntary protection measures, the report given Congress concludes that at least half of the population insures itself against medical costs; another 40 per cent

(Continued on Page 818)

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(Continued from Page 816)

handle these emergencies on a pay-as-you-go basis without hardship.

Those members of Congress who oppose the adoption of the socialistic schemes, such as proposed by the CIO, believe our system of free enterprise and constitutional government is the best in the world. Our Government may not be perfect but under its operation we have attained the highest standard of living and we are still a free people. Before the war the laboring men of Milwaukee owned and operated more automobiles than all Europe, including Russia, where they yet believe that only capitalists can have automobiles and bathtubs and such electric conveniences as refrigerators and ranges in their homes.

Is it not significant that it was necessary for capitalistic America to manufacture and supply the necessary military requirements for Communist Russia in the late war against Germany? That fact in itself should suggest something to those who now would abandon the American system and turn to one that has brought grief and disaster to every people who have tried it.—Congressman Paul Shafer of Michigan's 3rd District.

* * *

The Northern Michigan Medical Society held its June meeting at Indian River on June 13. Professor Paul D. Bagwell of East Lansing presented a fine talk entitled "Proposed National Health Legislation," to a professional audience numbering fifty-two. Among those present were doctors of medicine, dentists, pharmacists and legislators. Senator Otto Bishop and Representative Hugo Nelson were honored guests.

* * *

Henry R. Carstens, M.D., Detroit, past president of the Michigan State Medical Society, has assumed the position of Director of the Third Region of the Veterans Administration covering the states of Pennsylvania, New Jersey, and Delaware. Dr. Carstens took over his duties in Philadelphia on June 3. He has fifteen hospitals under his supervision. Colonel Carstens recently returned from Italy where he served as commanding officer of the 17th General Hospital, the Harper Hospital (Detroit) Unit. Dr. Carstens was Associate Professor for many years at Wayne University, as well as the Senior Attending Physician at Harper Hospital. The former Dean of Medical Service of Florence Crittenden Hospital, he was Michigan Governor of the American College of Physicians for a number of years. He has held the Presidency of the Detroit Academy of Medicine, Detroit Medical Club and the Wayne County Medical Society.

* * *

Associated Medical Care Plans, Inc., the new corporation formed by the Council on Medical Service and Public Relations of the American Medical Association, held its initial meeting in Chicago, April 27. Voluntary medical care plans representing nine states were admitted to membership: California, Iowa, Michigan, Ohio, Oregon, Pennsylvania, New Jersey, Nebraska and Surgical Care, Inc., of Kansas City, Missouri.

Purpose of the corporation is to intensify the growth and progress of the voluntary sickness insurance plans

(Continued on Page 820)



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WHAT'S WHAT

(Continued from Page 818)

in the United States. A second meeting will be held in San Francisco at the time of the American Medical Association meeting.

The Council on Medical Service and Public Relations has established standards which cover the costs of such service and the quality of medical care that is given under the insurance policy. The nine plans already admitted meet the standards of this Council. They will be given a seal indicating that they do meet the standards and are approved. Eventually, the purchaser of a policy covering medical care will know that those bearing the seal of acceptance of the Council assure him a high quality of medical care at the lowest possible insurance cost.

* * *

Department of Psychiatry at Wayne.—Appointment of Dr. John M. Dorsey as special professor and chairman of the department of psychiatry at the Wayne University College of Medicine, coupled with an anonymous grant of \$90,000, marks the University's expansion of its program in psychiatry. Dr. Dorsey, director of the Child Guidance Division of the Children's Fund of Michigan, will begin his new duties July 1.

"In securing Dr. Dorsey to fill this position," said College of Medicine Dean Hardy A. Kemp, "we have a man ably equipped to carry forward the work in psychiatry. The fact that he will devote full time to the position means that the program can now be enlarged to take

its place as one of the major departments in medical education."

The \$90,000 gift is to underwrite the expansion for a period of five years. The donor indicated that prior to the end of the period the program will be reviewed to determine whether or not the grant should be continued. The funds will be administered through the Wayne University Foundation, a non-profit corporation founded to act as trustee for the receipt, management, and disbursement of grants and gifts to Wayne University.

Dean Kemp speaks of the grant as a means of "preserving balance" in the training of doctors. Professional training in medicine, he indicated, could easily become overly mechanized in modern scientific society. "There is as much need today as there ever was for the physician, equipped though he be with every modern facility, to be sensitive to the mental states of his patients and appreciate their relationship to all-round health," Dean Kemp said. "The present donation will allow psychiatry to take its rightful place among the major departments of our curriculum." Beyond this, the Dean declared, the expansion of the program will enable the University to broaden its services to the entire community.

In addition to his association with the Children's Fund, Dr. Dorsey is a physician in the Harper Hospital staff and holds the position of lecturer in the post-graduate School of Medicine at the University of Michigan and of psychiatrist with the School Survey Committee of Purdue University. He is listed both in "American Men of Science" and in "Who's Who in America."

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FLUORINE IN UNITED STATES WATER SUPPLIES. By
Anastasia Van Burkalow. A pamphlet reprinted from the Geo-
graphical Review. The American Geographical Society.

THE PROGRESS OF MEDICAL GEOGRAPHY. Richard Upjohn
Light. Also, A Proposed Atlas of Disease with a note on ter-
minology of certain map symbols. By J. K. Wright. Reprinted
from The Geographical Review, The American Geographical
Society.

ORAL MEDICINE, DIAGNOSIS AND TREATMENT. By Lester
W. Burket, D.D.S., M.D., Professor of Oral Medicine, The
Thomas W. Evans Museum and Dental Institute School of
Dentistry, University of Pennsylvania. With a Section on Oral
Aspects of Aviation Medicine By Major Alvin Goldhush, D.D.S.,
M.S., D.C., A.U.S. 350 Illustrations, 60 in colors and 10 plates.
Philadelphia: J. B. Lippincott Company, 1946. Price \$12.00.

This is a complete textbook of the relations of disease
to mouth manifestations. The importance of history is
stressed, and many laboratory tests described. The first
chapter is on fusospirochetal disease (Vincent's infection).
Minerals and allergies receive a chapter each. The
tongue, the dermatoses, gingivitis and respiratory dis-
eases are all included. Each is well illustrated, the de-
scription is clear, giving forms, bacteriology and treat-
ment. Then endocrines, cardiovascular diseases all have
their special manifestations in the mouth, as have the
blood dyscrasias, syphilis, nutritional diseases, vitamins,
tuberculosis, focal infections. This adds up to an im-
posing book, and one that no doctor of medicine, not to
mention the dentists, can afford to be without. Here he
will find answers to questions arising every day.

DISEASES OF THE ADRENALS. By Louis J. Soffer, M.D.,
Adjunct Attending Physician the Mount Sinai Hospital, New
York City. Illustrated with 42 Engravings and 2 colored plates.
Philadelphia: Lea & Febiger, 1946. Price \$5.50.

The knowledge of the adrenaks has greatly increased
in the past few years, and this book brings the student
and practitioner up to date. Anatomy and morpho-
logical structure are mentioned, then a chapter on the
mechanical and chemical methods used in the study
and diagnosis of adrenal disease. Physiology occupies
two chapters, then Addison's disease. This is a complete
exposition of the disease with all its manifestations and
treatment. Other diseases referable to the adrenal oc-
cupy two thirds of the book. It is very instructive and
valuable to the internist.

A MALARIOLOGIST IN MANY LANDS. By Marshall A.
Barber, M.D., Chief of the Division of Parasitology, U. S.
Army. With a foreword by Paul F. Russell. Lawrence, Kansas:
The University of Kansas, 1946. Price \$2.50.

Dr. Barber in his work has visited every part of the
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a report. It is not technical, but is accurate. The story
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(Continued on Page 824)

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(Continued from Page 822)

SUGGESTION AND HYPNOSIS MADE PRACTICAL. How to Get What you Want. By Samuel Kahn, M.D., Ph.D., Author of Psychological and Neurological Definitions, et cetera. Formerly Clinical Professor of Neurology and Psychiatry at Georgetown and George Washington Universities, et cetera. Boston: Meador Publishing Company, 1946. Price \$3.00.

This book seems to be written partly for the use of the "intelligent people" who want to handle their relatives and friends efficiently. There is a chapter on suggestion in medicine, and one on suggestion in business also one on rumor and propaganda. It is an interesting book, easily read and contains valuable suggestions.

COSMETICS AND DERMATITIS. By Louis Schwartz, M.D., Medical Director United States Public Health Service, Adjunct Professor in Dermatology, Georgetown University School of Medicine, et cetera, and Samuel M. Peck, M.D., Medical Director (R) of the United States Public Health Service, Associate Attending Dermatologist, Mt. Sinai Hospital, New York City, et cetera. New York: Paul B. Hoeber, Inc., 1946. Price \$4.00.

The available literature on cosmetic dermatitis is studied and the results are made available here. It is only in the last ten years that cosmetic dermatitis has received the attention it deserved from the physician. Formulas of most cosmetics are given, the diagnosis and patch tests, and treatment. A valuable book for all physicians dealing with the effects of cosmetics, and the care of these lesions.

RORSCHACH'S TEST. II. A variety of Personality Pictures by Samuel J. Beck, Ph.D., Head of Psychology Laboratory, Department of Neuropsychiatry, Michael Reese Hospital, Chicago; Associate Professor of Psychology, Northwestern University. Foreword by Roy R. Grinker, Lt. Col., MC. New York: Grune & Stratton, 1945. Price, \$5.00.

The Rorschach method of dynamic personality evaluation is by no means new: it is a quarter century now since the publication of Dr. Rorschach's *Psycho-diagnostik*. The fact that the test now has a widespread acceptance in psychiatry, psychology, and social work is a tribute to the efforts and earnest belief of the pioneers in the fineness of their psychological instrument. Dr. Beck is to be counted among the pioneers.

This volume is the companion work of his publication of two years ago, wherein he elaborated the basic processes implicit in the objective application of Rorschach symbolism and statistics. At present his focus of attention is almost wholly on test interpretations. Under the subtitle of "A Variety of Personality Pictures," this collection of Rorschach records represents in essence a summation of his total clinical experience with the test. As he states in his preface, "It embodies progress in interpretation since the publication of my *Introduction to the Rorschach Method* in 1937, assimilating both the advances reported by others, and my own enlargement of experience growing out of my work at Michael Reese Hospital."

The interpretation of a Rorschach record, as sampled here, approaches the status of a fine art. It involves an appraisal of each response as it is offered, an analysis of the subject's total and specific behavior during the examination, and a quantitative and qualitative study of the scores. The process further presumes an evaluation of the results in terms of recognized norms, in the light of their unique inter-relationships, and against the background of the individual's case history. Dr. Beck demonstrates a remarkable facility in the balancing of all these factors and in producing therefrom a functional picture of the personality as a unit organism that is constantly adjusting under the impact of diverse forces.

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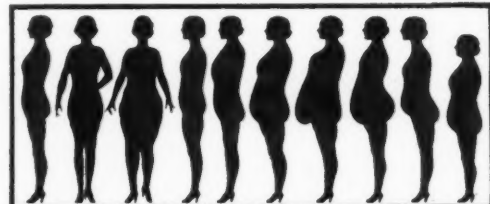
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(Continued from Page 746)

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Officers who return to duty under the plan would hold the same grade they held while on active duty prior to separation. Plans are under consideration at present to provide a permanent place in tables of organization for dietitians. Advisability of incorporating dietitians in the Army was demonstrated by their exceptional wartime accomplishments.

CONSULTANT SYSTEM CONTINUED

Outstanding success of the system of appointing professional consultants in medical and allied specialties born during the war will be continued and extended, Major General Norman T. Kirk, The Surgeon General of the Army, recently announced.

Consultants who have gained recognition in their fields will be designated by The Surgeon General in such specialties as internal medicine, surgery, neuropsychiatry, preventive medicine, dentistry, veterinary medicine and other special medical fields. Senior officers in those fields may recommend appointments in special subjects and the appropriate commissioned officers or qualified civilians for a consultant post.

"By continuing the system of employing consultants we will insure maintenance of the Army's high medical standards," General Kirk stated. "Consultants, acting as representatives of my office, will evaluate, promote and improve the quality of medical care and sanitation."



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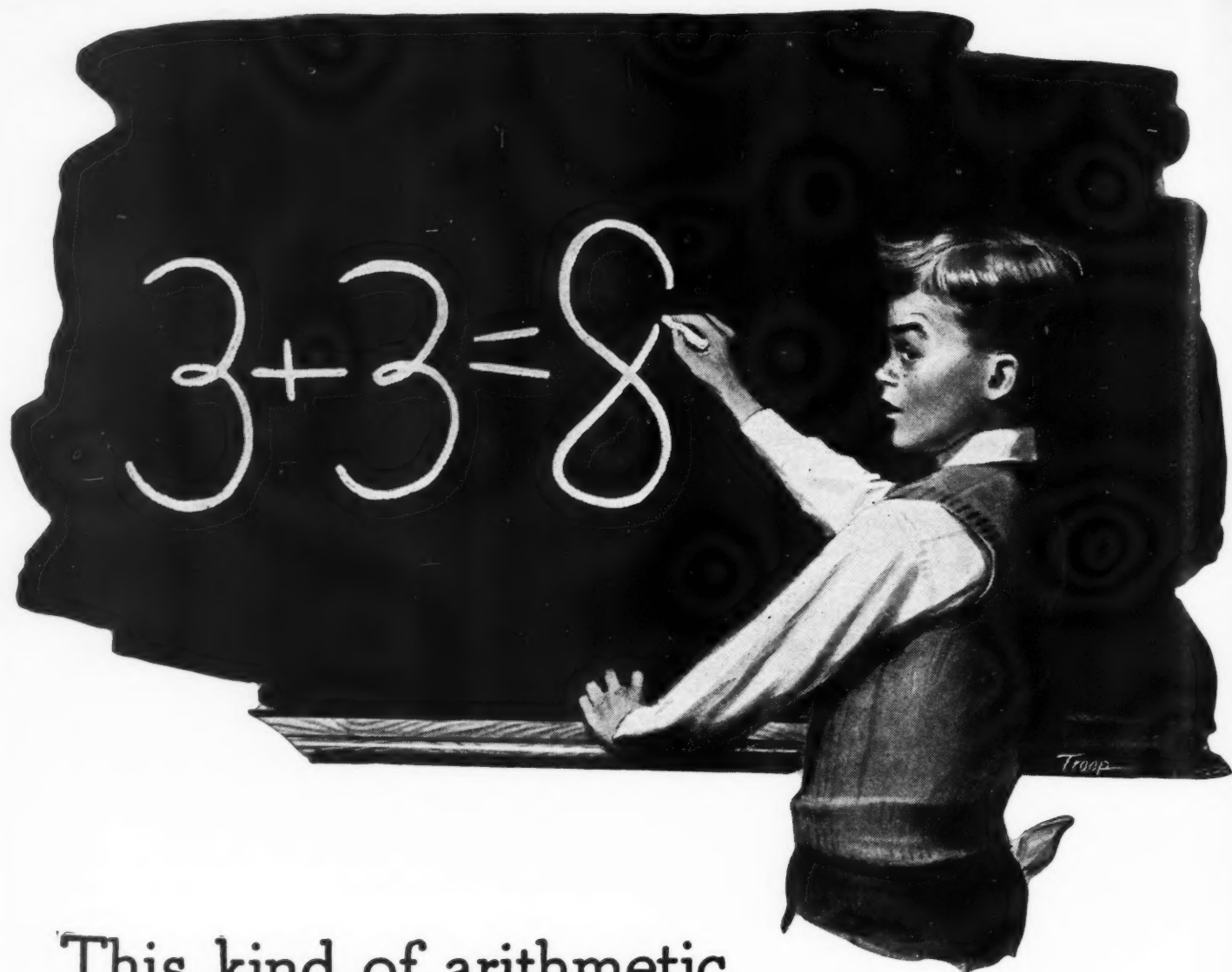
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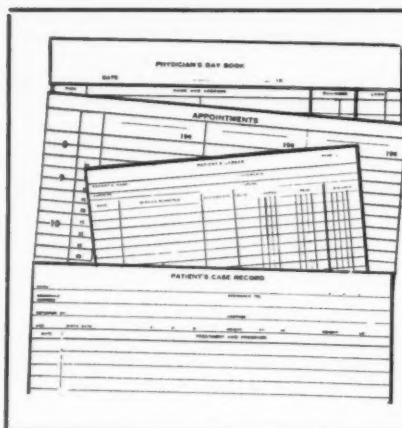
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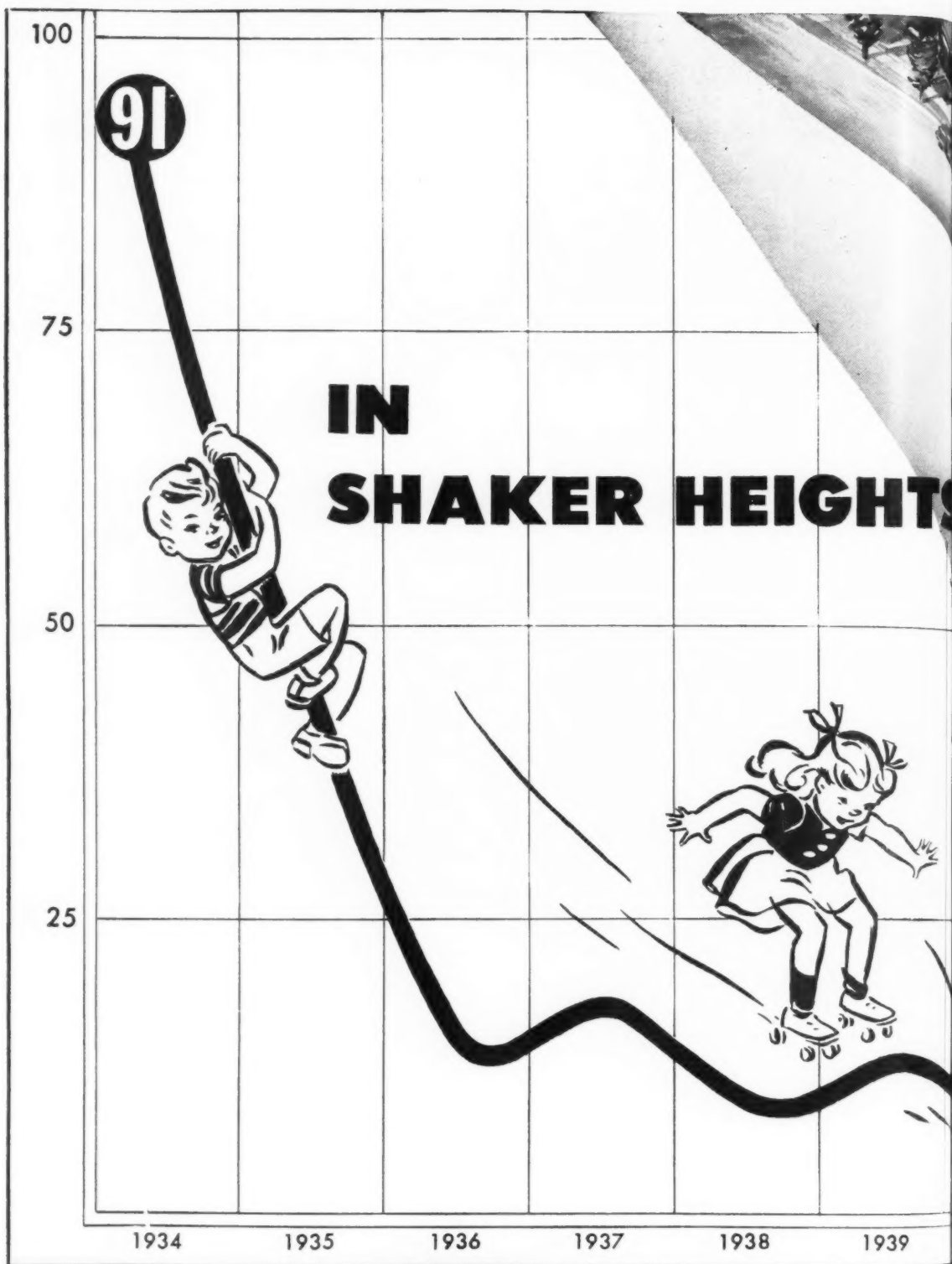
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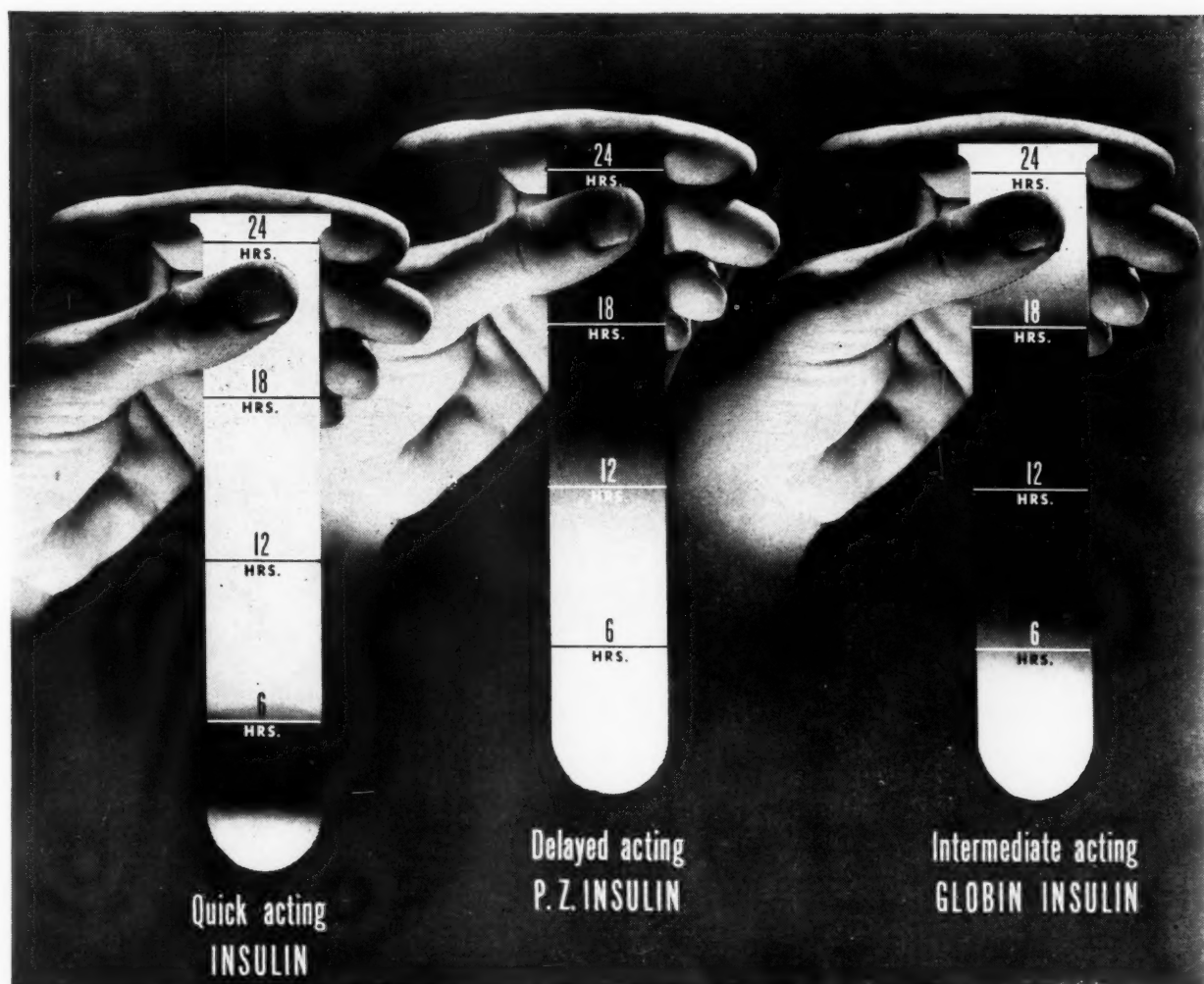
Burton R. Corbus, M.D.
Grand Rapids
MSMS President
1939-1940



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These products are hypo-allergenic.

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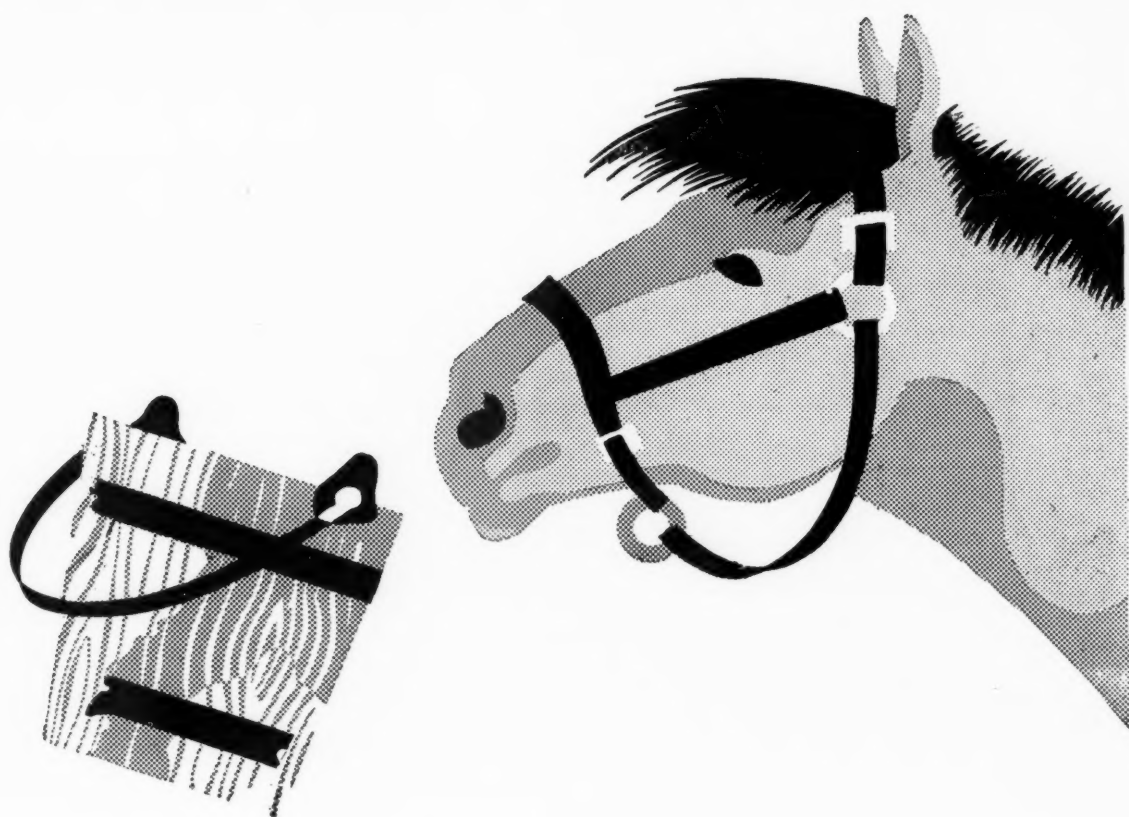
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and the same is unfortunately true of too many human beings for whom well rounded diets have been prescribed. When long-standing eating habits interfere with conversion, the use of potent, easy to take, and low cost supplementation with reliable Upjohn vitamins can help assure vitamin adequacy.

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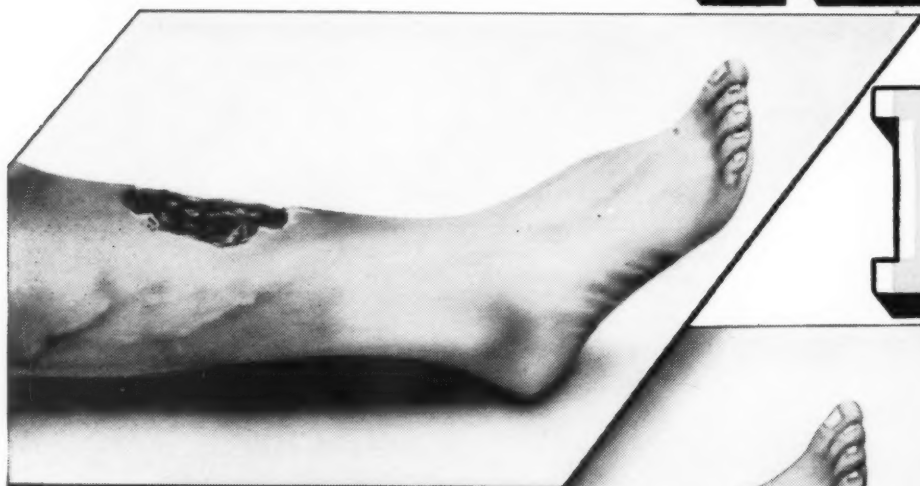


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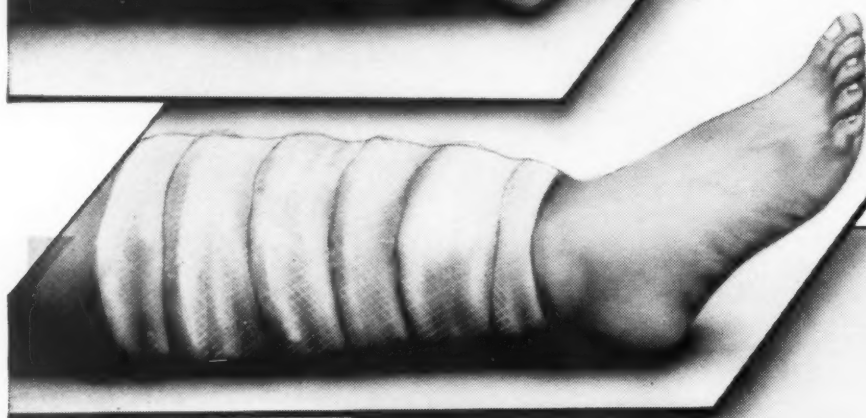
Henry R. Carstens, M. D.
Detroit
MSMS President
1941-1942

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*Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154

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H. H. Cummings, M. D.
Ann Arbor
MSMS President
1942-1943



ONE

OUT OF EVERY 200 PERSONS
is an epileptic. Economic
loss, measured in money, is
tremendous — amounting
to \$60,000,000 annually.



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¹ Virginia M. Monthly
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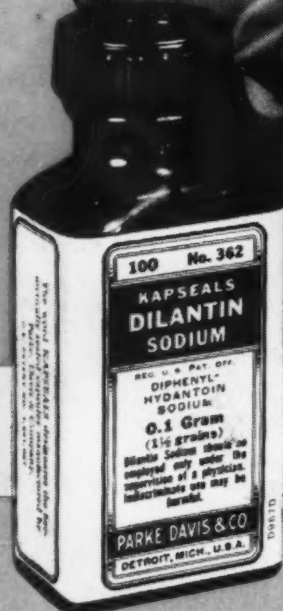
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A. S. Brunk, M. D.
Detroit
MSMS President
1944-1945



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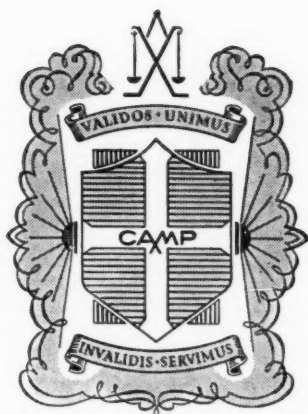


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